Department of Human Services

Juvenile Justice Information System (JJOLT)

Training Manual

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SECTION 2

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Department of Human Services

Juvenile Justice On-line Technology

JJIS

Training Manual

FOR DETENTION CENTER STAFF/ PROBATION OFFICERS / COURTS

Client Management Session

4.0 Hours

Objectives:

To ensure the operator can log on to JJIS and knows how to change passwords
To ensure the operator knows how to log off of JJIS
To give the operator an overview of the Client Menu
To ensure the operator knows some of the key forms in JJIS

Content Overview

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Termination
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Misc. System Functions
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Session I - Pre-Logon Basics

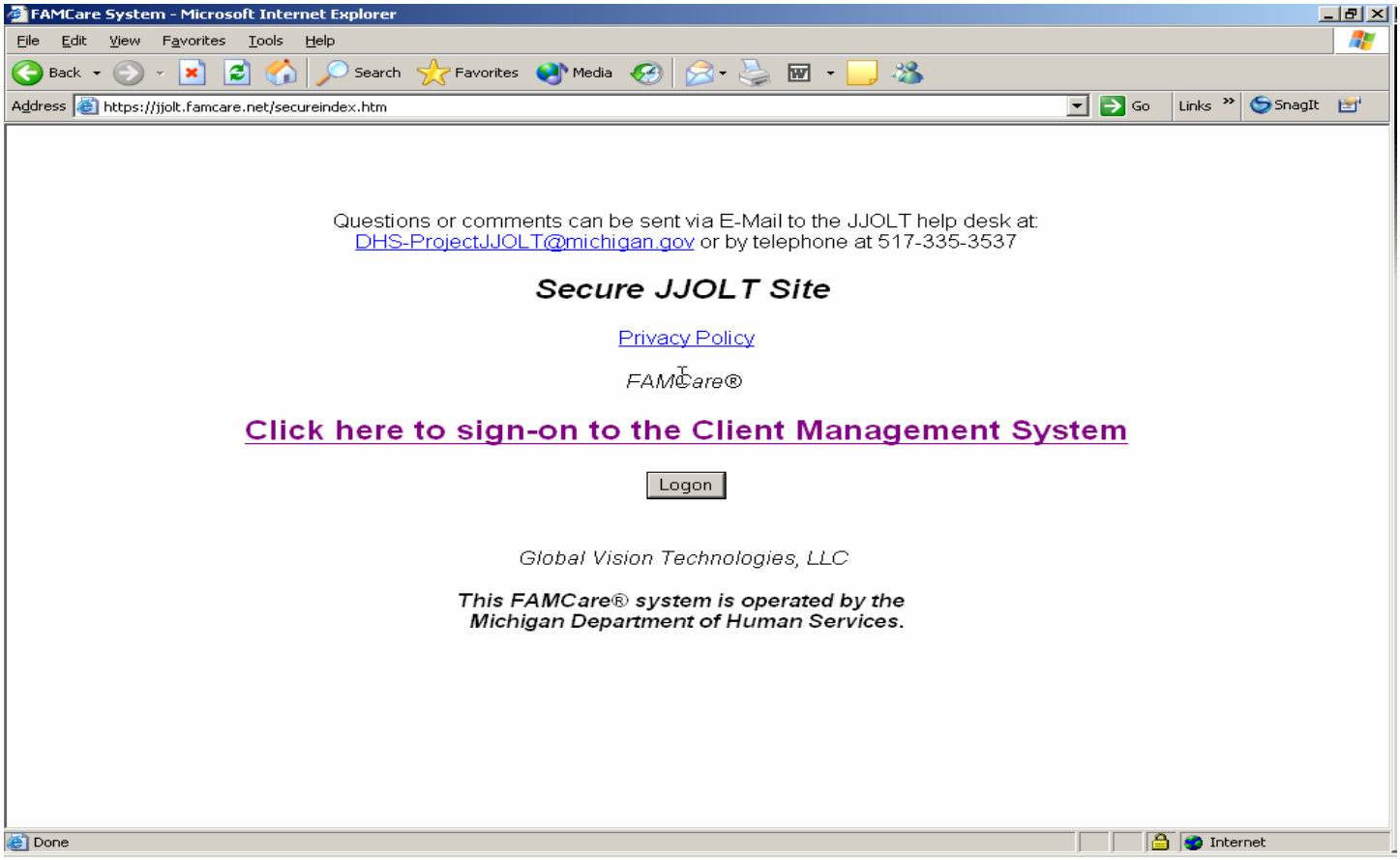
Start/Programs/Internet Explorer E-mail address; DHS-ProjectJJOLT@michigan.gov

Address: HTTP://FAMCAREACCESS.COM/JJOLT

Help site; www.michigan.gov/dhs - click on Juvenile Justice

Training site, HTTP://JJOLTTRAINING.FAMCARE.NET

The screen below is the sign-on screen for JJIS. Place your cursor on the line that states "Click here to sign on to Client Management System" and press the left button on the mouse or hit the "Enter" button on the keyboard.

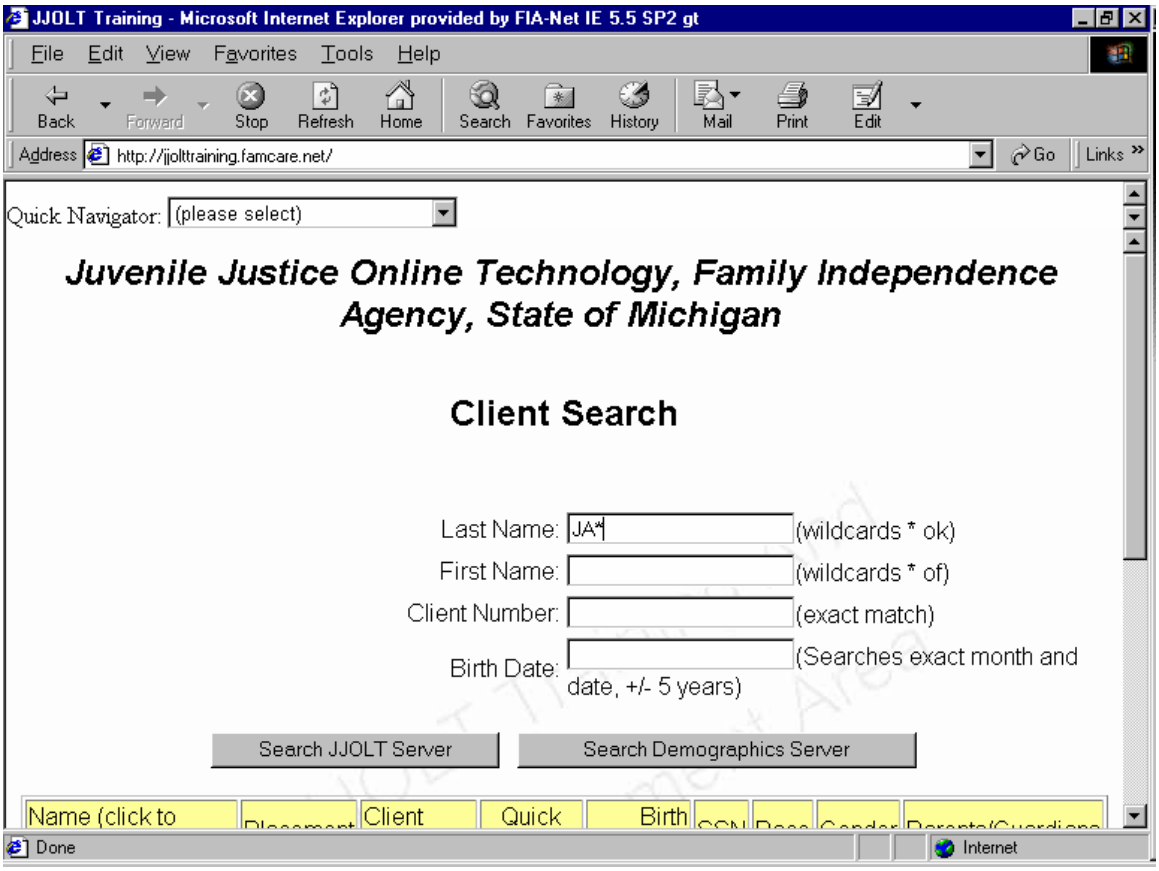


This brings up the sign-on screen, as well as a gray screen that contains the "Redistributable Code Agreement." Click on the "OK" button on that screen, which will then leave the sign-on screen, as show n below.

From this sign on screen, enter your user name (First-Last) and initial password you are given (123456), **then go down to "New Password" and create your new password**. Confirm it, then click on the "Logon" button. This will produce the main master session menu (next page). **DO NOT CLICK ON LOGON UNTIL YOU CREATE YOUR NEW PASSWORD. YOU MUST CREATE YOUR OWN UNIQUE PASSWORD THE FIRST TIME YOU SIGN IN. ALPHANUMERIC, AT LEAST 2 LETTERS OR NUMBERS!**

You will then get a message that your password has been successfully saved. Click to continue. You will get a message every 2 months to update/change your password.

This will be the main screen you see when you sign on. This is a client specific program and you must search for your youth first before you can just add a new record.

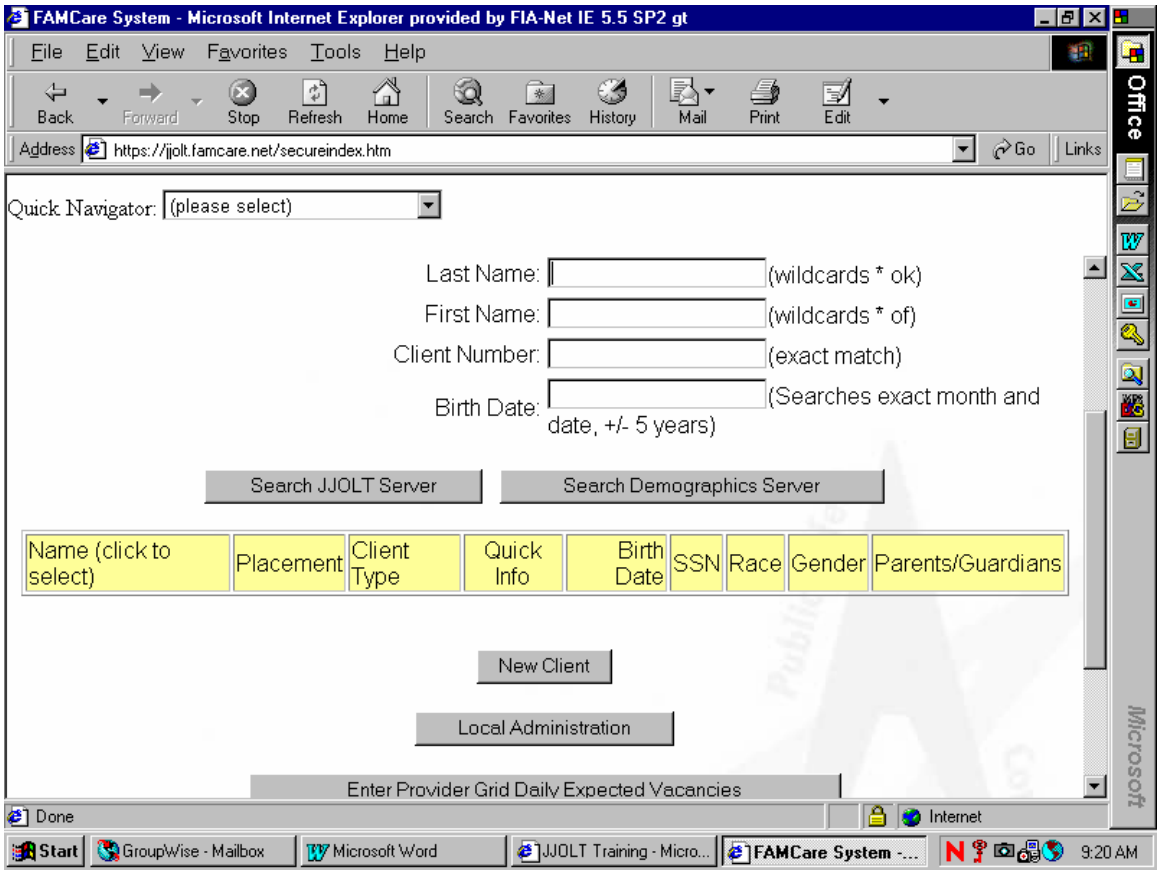


To generate a list of Clients using the "Quick Client Access" section, select a field (preferably Last Name) and type the first few characters that are known, then add an asterisk (*), which is a wild card (for example Ja*). First select the Search JJIS Server Button. If you still do not see the client that you are searching for, and then select the Search Demographic Server Button, This will produce a list of Clients that have those characters in common. **Please search for, as few parameters as possible, (do not type in full name)**. This will insure that we are not creating duplicate records. This is very important when we have clients that have difficult spelled names, or we have 2 kids with the same name, but different birth dates etc… When you get the screen that lists all the records, you can see which clients are "active," which are "enrolled" etc…

If you do not see the client on the list, this means that you need to do another search using fewer parameters (again search only for a few letters in last name only). You may at times be assigned a youth that is not already in the system, if you still are unable to find a youth, you will need to create a new client record.

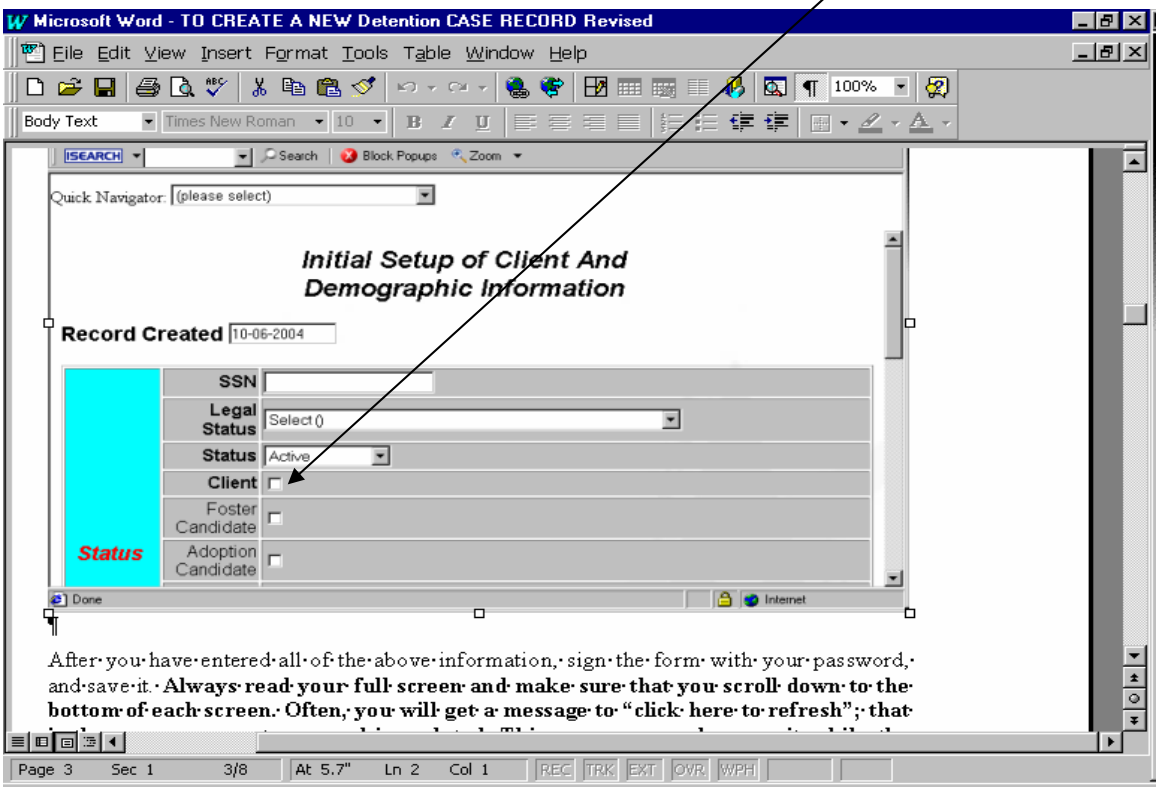
The JJIS system will allow you to create a case build, including each of your clients shown on one main screen. Please refer to the (How to set up your case load) on pages 10-18 of section 1 of the JJIS user guide. You can access this guide at www.michigan.gov/dhs

If you are still unable to find the client that you are searching for, please follow the steps listed below for creating a new case record



Click on the <u>New Client</u> button located at the bottom of the above screen. This will bring up a Client Demographic screen, please see below.

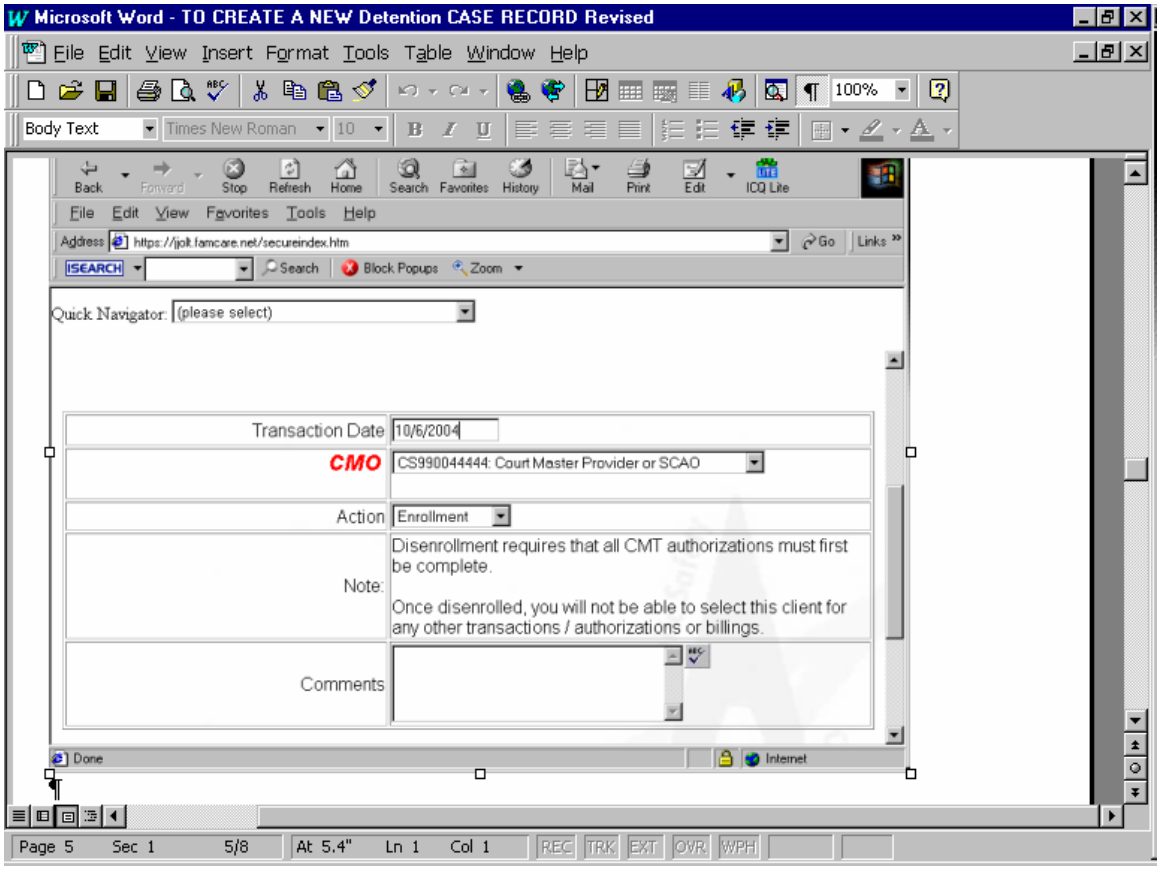
When creating a new record, you must place a check mark in the client box. **The required fields are the client's first and last name, gender, race and legal status.** You can also add the social security number if known. The system will automatically generate a Client Number that is unique to this new client.
At the *Initial Setup of Client and Demographic Information* screen, also begin to add current address, phone Numbers, weight, height, hair and eye color, social security number, race, religion, ethnicity, language, and any additional information that you have. You may also add client and family history, if known.



FIRST: you must scroll down or use one of the links in the upper right hand corner to verify the **"CMO Enrollment/Disenrollment**"After creating a case record; it will automatically enroll your client to the top parent provider, which is the court for your county.

NOTE: Always make sure you also maximize the screen you are working on; this will ensure that you do not X out of your main screen, or close a form that you are working on without saving the information first.

To enroll/disenroll:



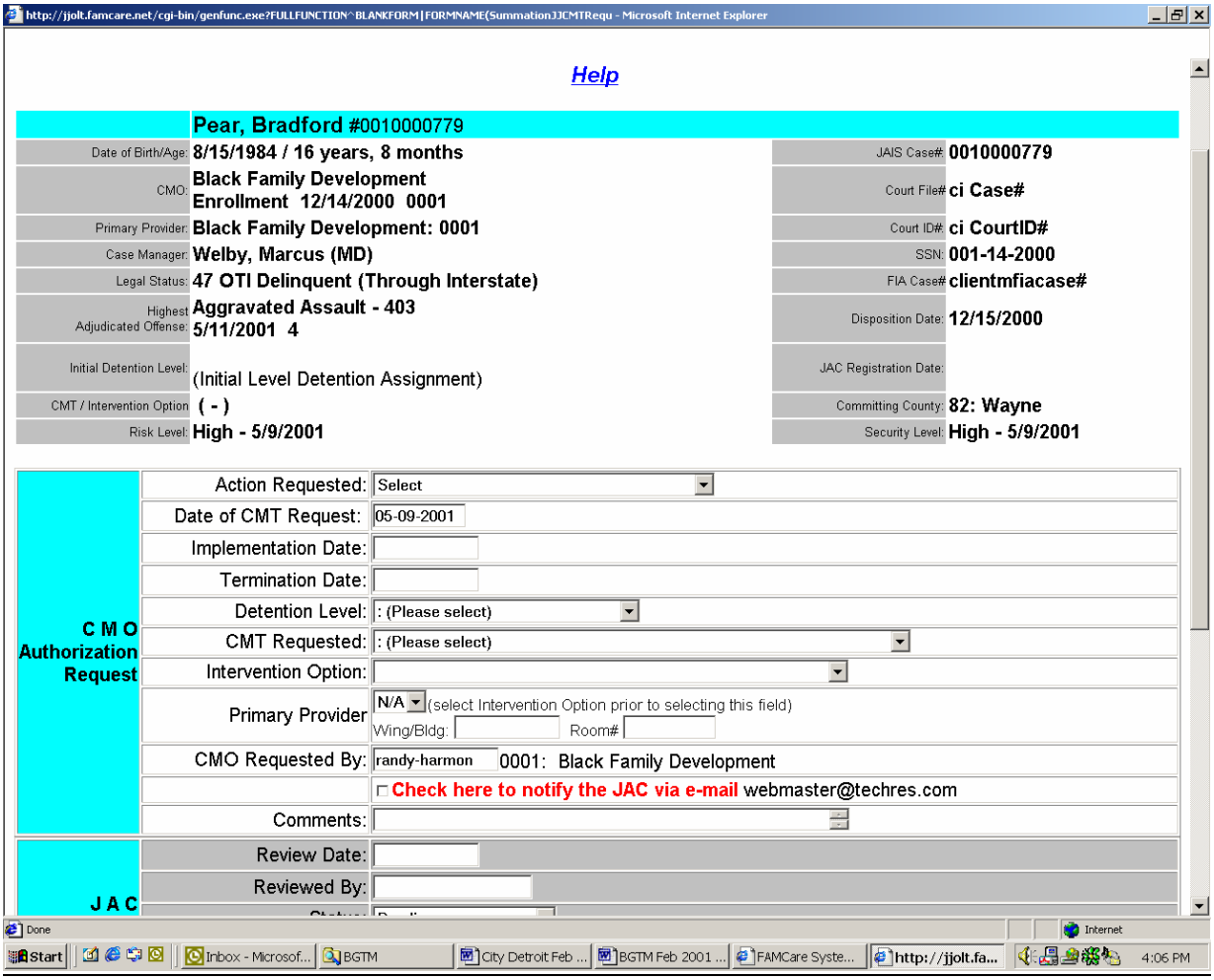
1. Ignore the Zip Code field.
2. Select CM Put in transaction date. You can use either the current date or the acceptance date, either will work.
3. CMO box (Click the 'arrow') and highlight "Master Court Provider or SCAO"
4. Action should prefill with "enrollment"
5. Sign the form with your password and save it.

A "Confirmation Screen" will appear. This screen allows for capturing the "Intake Record" in a printable format or continuing with further input for this Client. Press the "Click here to continue" button. This will bring up the "Intake Record" again. Either continue to make entries or scroll down to the bottom and save the form in its current status.

Once the intake record has been saved, the "Save Confirmation" screen appears again. Select "Click Here to Continue." This generates the "Forms Menu" (shown below), which contains all of the forms for the new Client. This screen will be described in the next section.

Care Management Track

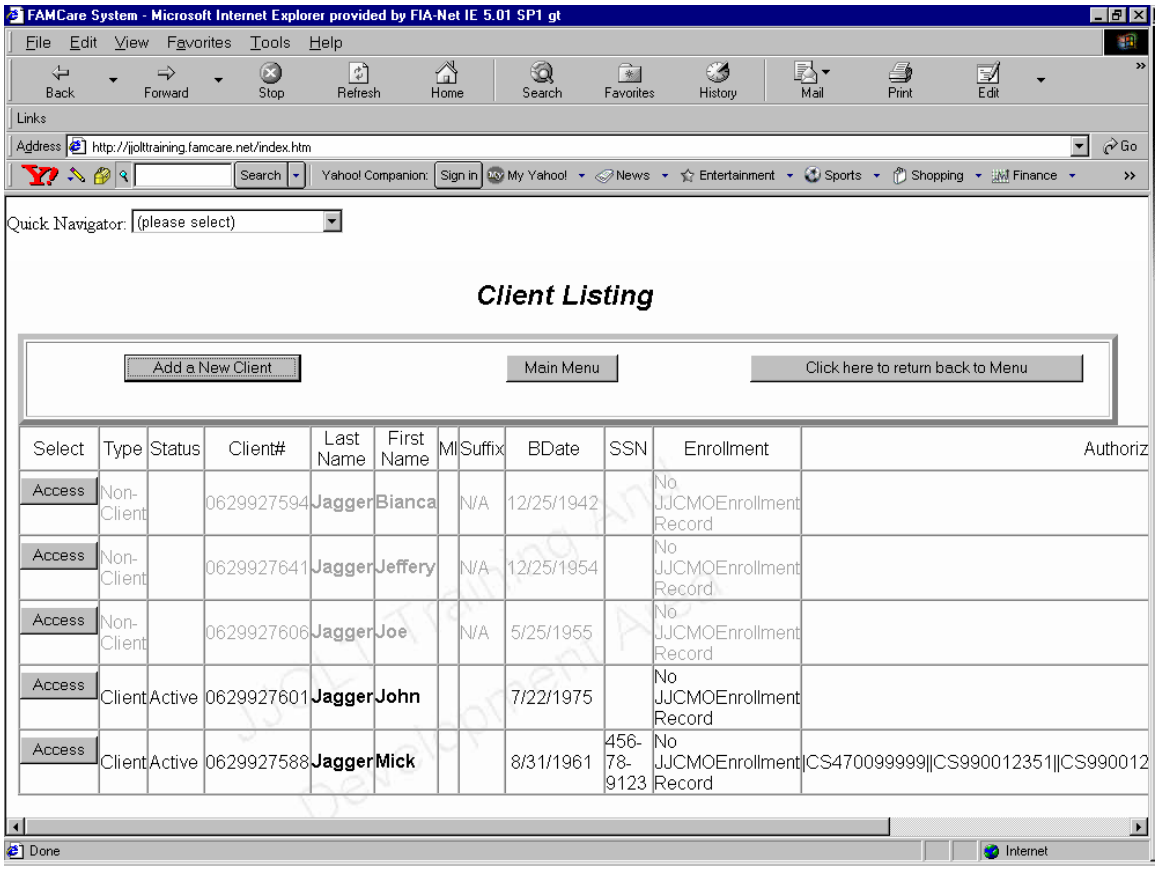
SECOND: In the future you will add a Care Management Track for all youth. This is the main section relating to the activities required for a youth. The "Care Management Track Authorization Request" is an interactive form used by BJJ requesting any community-based program, a residential program, or Detention program for reviewing the record and placement of youth.
We will just briefly explain to you how the form works. From the "Intake Summary" for the Client, and select "click here to add" "



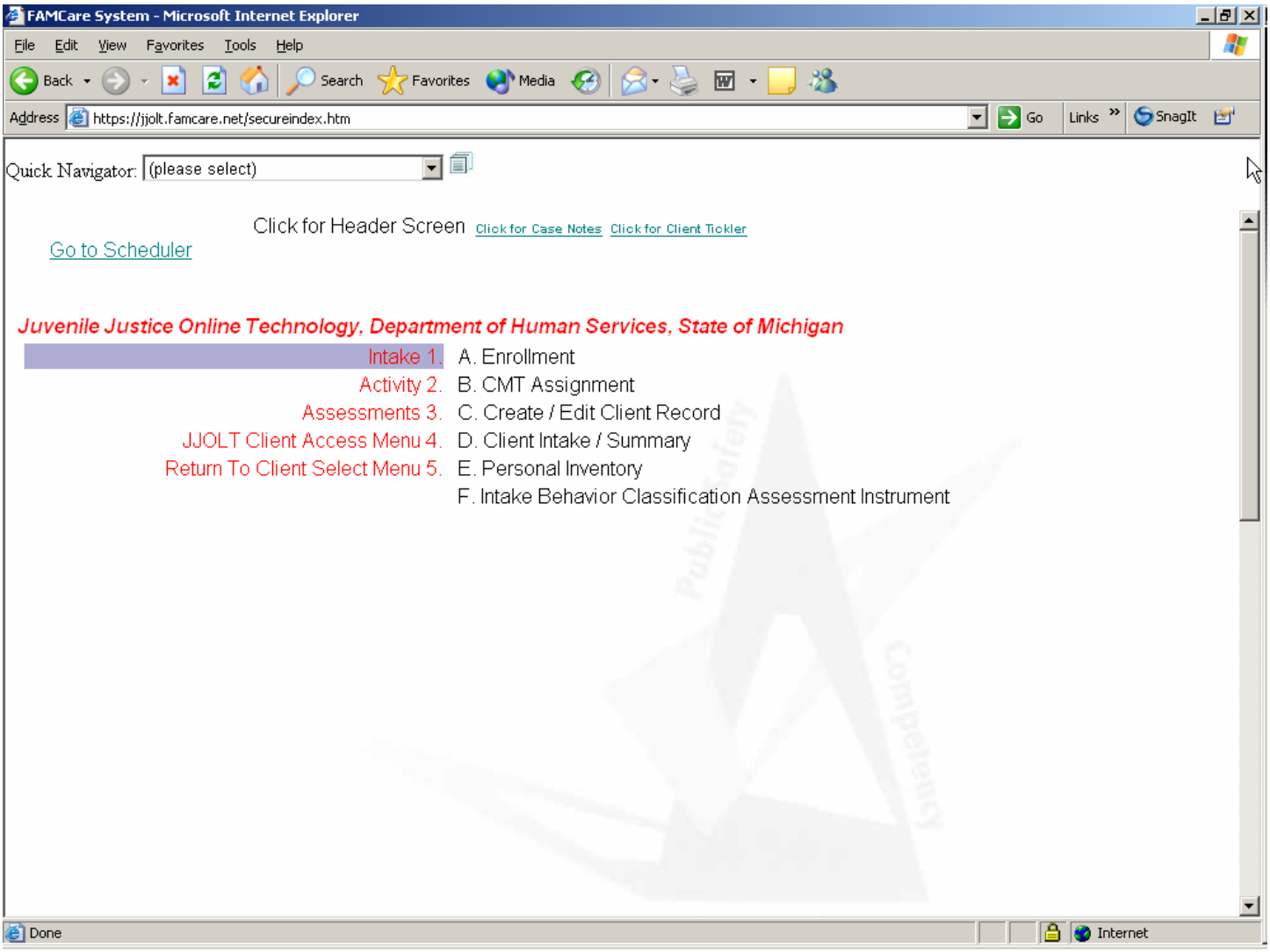
1. Action Requested = Initial Detention CMT if this is a first time placement. Supplemental Detention after initial.
2. Implementation Date = Date the Service is to begin (Admission Date)
3. Termination Date leave blank.
4. Detention level – Secure Residential Detention
5. Service Category Requested = Residential-High Security
6. Service Option = Short Term Detention (High)
7. Only the Primary Providers who have that type of programming will be among the choices i.e. GVRC (county), Shawano, Washtenaw Youth Home, etc. Authorization status is Active And Approved
8. Sign, Save and Refresh

This will also now automatically update the Placement History when you 'refresh' that section.

To access a specific Client, click on the “Access” button next to the Client’s number and name. Check to make sure this is the same youth you are looking for by viewing the Date of Birth/SSN if available. If it is correct, this will bring up this youth’s record and you can begin to add updated information.



Clicking the “Access” button brings up this “Forms Menu”.



Client Intake Forms (Menu Option 4-D)

Forms Menu

The top of the page contains the Client’s system-assigned number as well as name. The forms are organized into categories. To open a form, select the category on the left column and then click on it, which generates another list of forms. As each form is built, it automatically populates other required forms for this same Client.

There are detailed “Help” screens that walk a user through the Client record building process. Select the proper “Go” button for the necessary help.

Quick Navigator

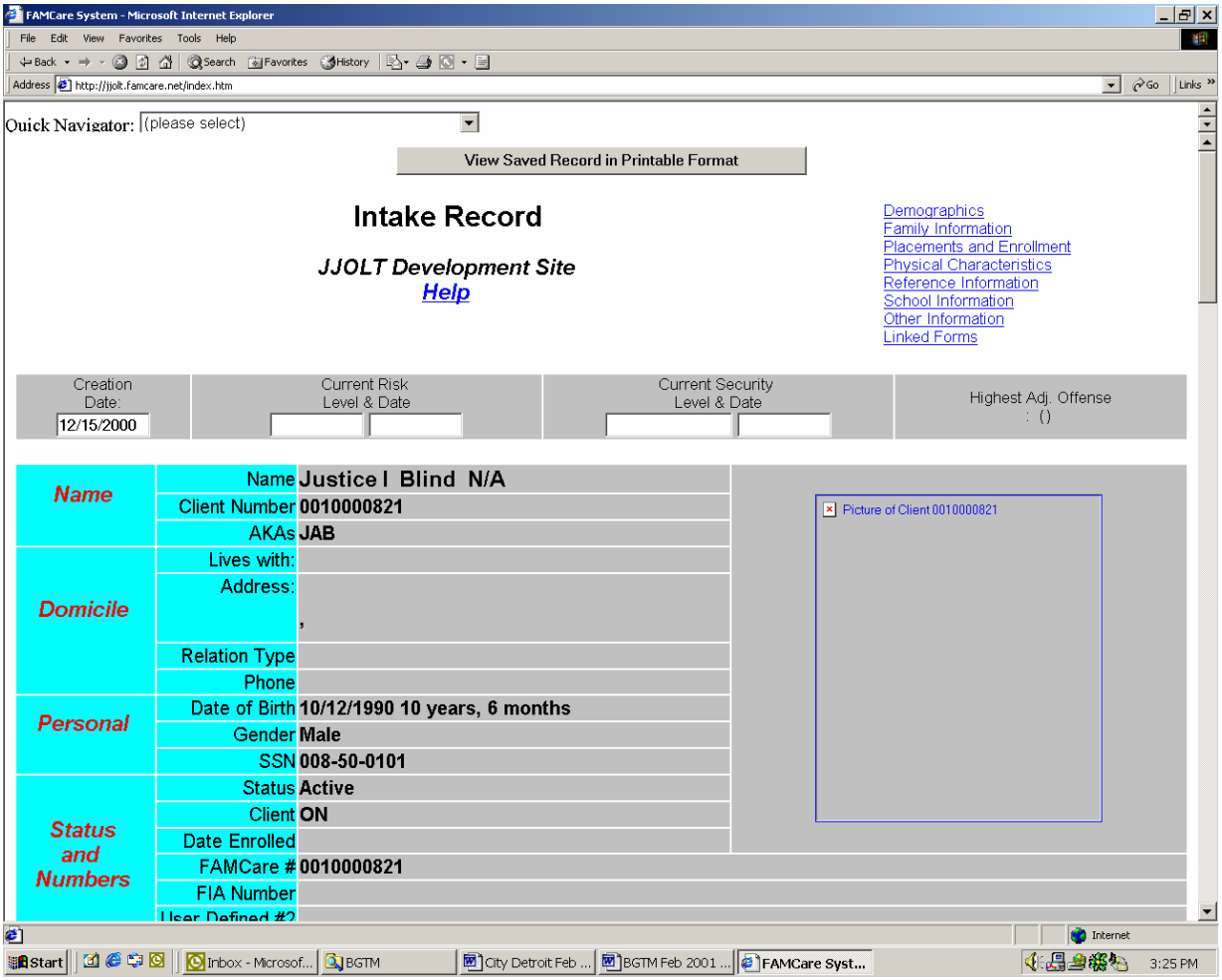
At the top of the main screen you will also see a "Quick Navigator" bar. Clicking on the field produces a small dropdown menu of the different areas for which the user has been granted access. This allows to more efficient movement around the system to avoid backing out of various screens to reach the main menu. You can return to the "Client Menu" screen to find another client, or you can go to the Main Forms menu for the client you are currently working on, or you can Log Off the system. **If you see this Quick Navigator you always know you are in the main screen, and this is how you move around the system. Do not use the X button at the top right hand side of your screen to close out, this will take you out of the system, and you must start all over, and you may lose information you were working on. The same is true for the 'Back" button, you may not save the information you were working on. Get in the habit of using the Navigator.**

If you accidentally X out of the system, you will have to log back in to JJIS, sign in again, restate your password, and search for the youth record that you were working on.

As you are working in the system, often you will be adding information to "Forms within Forms". Look for your Quick Navigator, if you do not see it you can use the X button to close out of that particular form.

Any time you add information to a form, you must SAVE, and then follow your screen buttons to refresh, if you are just viewing a form you can X out of it if you have not added any information.

The "Client Intake / Summary," form **4D** continues for many pages. It is the critical form for entry into the system.



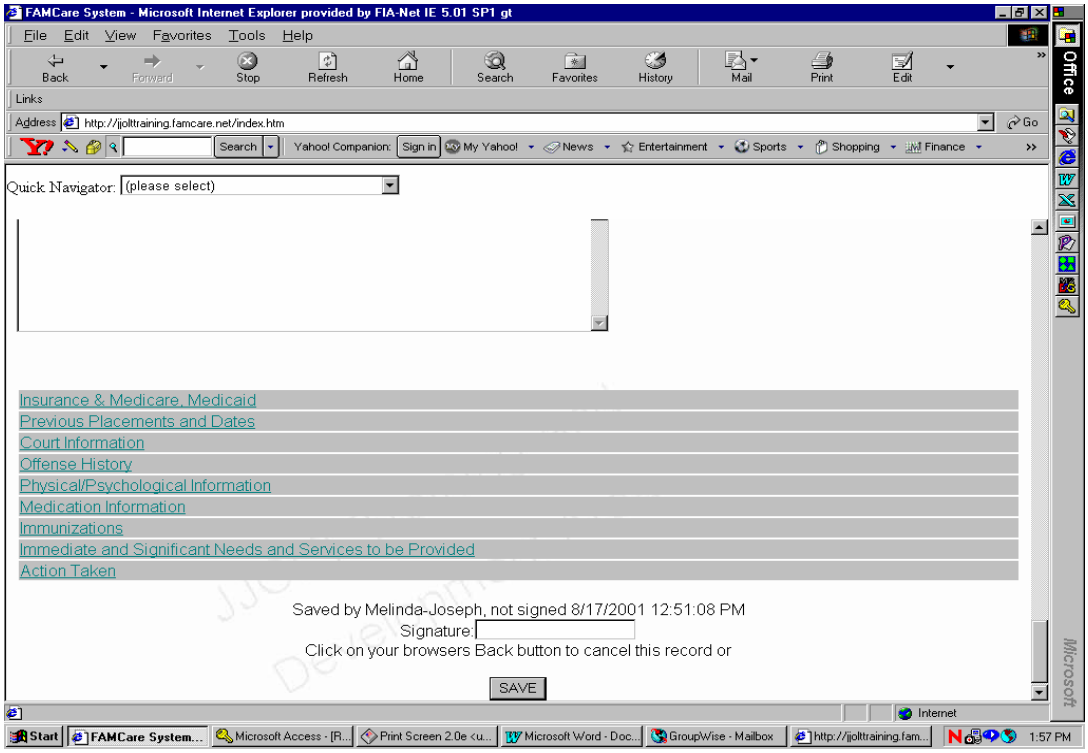
Note at the top of the form the Client's current Security and Risk Levels. These are pre-populated from risk assessments. There is also a box with the "Client's Highest Adjudicated Offense," which is pre-populated from "Offense History." You can also add

The top of the "Intake Record" form also shows links to various sections of the form, which are just shortcuts vs. scrolling down the page. The "Intake Record" also contains links to several other screens that supplement the basic Intake form.

Other Links on the "Intake Record"

Other links are described below, which allow for more complete data entry during the Intake process. These screens can also be accessed later through the "Forms Menu."

Regarding all the items in this section, once input is complete, click on "Save" to save the input or the "Back" button on the browser menu to cancel the input. An option exists on the "Save Confirmation" screen to also print out a hard copy of the record. Completion of this task and hitting the appropriate button on the "Save Confirmation" screen will take the user back to the "Forms Menu" for that Client.



Parent/Guardian Information or Contacts

The "Parent/Guardian Information" link provides significant information regarding all contacts involved with the Client and the treatment plan. Each Contact record will contain data regarding that person's relationship with the Client, privileges, role in treatment, demographics, insurance (if applicable) and possible restrictions regarding visitation.

To begin

1. "click here to add"
2. This will bring up a Search Screen. Again, you must search for this contact, as they may already be in the system as a contact for another youth. Type in the contacts' last name (also using a wildcard Ja*). If they are in the system you can just click on their name and add the new information. If not you must click on the "Add a new contact to the master record"
3. Add all know contact information (name, DOB, Address, phone, etc.)Sign and save this form.
4. You then must add Relationship details. It will only show up on the intake record as a Parent or Guardian if you have checked those boxes. Also, if you check Main Domicile, you will change the youth's main record to the parents' address. Also, it will only show up as Contact Restrictions if you check the appropriate box.
5. Sign the form, Save it and then you will get the confirmation screen. Scroll down until you see the Click here to refresh summary, and you will then return to your main Intake record, and the information added should be there.

Continue to Scroll through the Intake Record adding all information available. Case manager is the JJS worker. Committing County and Referring County, Committing Offense, Religion etc.

At the bottom of the screen you will see links for Offense History, Medical /Psychological Information, medication Information etc. Add all information that you have available. If you do not have it, that is OK, only add what you know.

Previous Placements and Dates

This part of the form is automatically updated when the Intake Unit admits a youth to a program; you should not have to add any information to this section. This will also pre-fill in the appropriate areas of your Treatment Plans.

Offense History

This form is self-descriptive, allowing for input of the Client's offense history. For each Offense, and Adjudication date and status must be filled in.

Physical/Psychological Information

This form is self-descriptive, allowing for input of the Client's current physician and psychiatrist, the date of the last physical exam, and notes. A link is also provided to the Medications and Immunizations forms.

Medication

The "Medication" form is used to document all medications prescribed for the client, including prescription number, pharmacy name, referring physician, dosage and any special instructions. Each type of medication requires a separate record, which can also be edited. This section is required for all agencies to keep updated. Any time a youth has a medication change, the Group Leader, Medical staff, or whoever is assigned must go in and complete this information.

Immunizations

The "Immunizations" form is used to document any immunizations that the Client has received and also to input those that are necessary but not yet received (or expired). You may also be able to scan in an immunization record so it is always available.

Immediate and Significant Needs and Services to be Provided

This form consists of text boxes for special notes regarding the physical needs of the Client and/or emotional needs of the Client and parent. This is excellent for intake staff and would be helpful if staff kept this up to date.

Saving Information

At the end of your Intake Summary, one last time you must sign and save your complete form. The computer does not know that you are actively working on a record unless you are hitting any save button at least hourly. If you have not done this, you may get kicked out of the system and not even know it, thus none of your information will be recorded. **Make sure you are saving regularly!**

CONTACTS/CASENOTES

Some people prefer to create Case Notes/Contacts as they occur individually, and some prefer to jot them down on paper then add them all at once while writing a Treatment or Service Plan, and Progress reports. Either way, the data entry is the same.

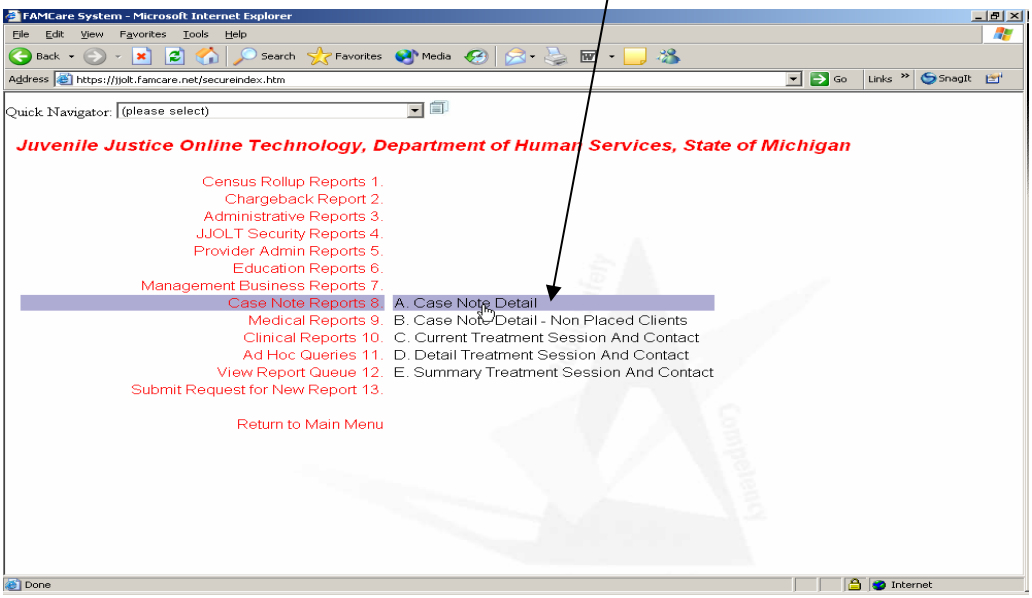
Click on the ***Add Case Notes*** anywhere from within 4E, from 8B, or while in a Progress report.

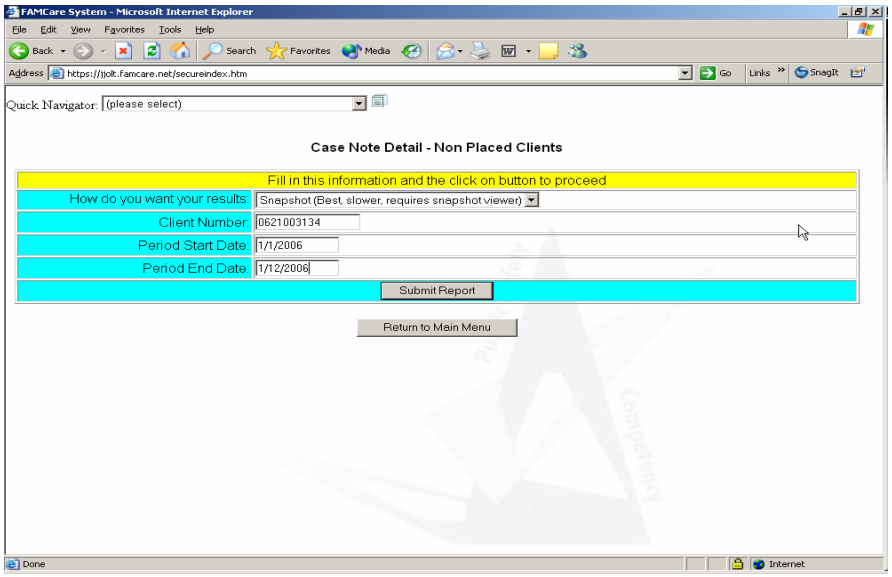
1. You will type in the date the case note occurred, time is optional.
2. Select the type of contact from the drop down box.
3. Select the contact person (you can select multiple people by hitting your control button and your mouse at the same time to select or deselect multiple people). If your contact is not listed, you will click on ***Add Contact***, and refer back to Parent Guardian info section to create a contact and relationship. Also you can check whether the JJS was a part of this case note by checking that box.
4. Remarks is a brief description of the case note that will appear on your report, Description is a more in depth text of what occurred. Someone would have to open this case note up directly to get this description.
5. Select where you want this case note to populate i.e. Progress Report, Treatment Plan, Service Plan (for JJS workers only) Medical etc… Most of you will always select Progress Reports.
6. There is a Private box, these are notes that only you will have access to. No one else will even see that they were created. This is generally used for the Clinical Psychiatric staff, but if you use this selection these will not show up on Progress Reports.
7. Your choice then will be to either **Quick Save**, which will then allow you to add another case note and so on until you have added all that you wish, or **Save/Close** which will save that case note and return you to the main form you were working on. (You can also cancel the case note and return to your form etc…) The schedule button is not a functional part of the case note section at this time so you do not need to worry about this at this time.

Your case notes that occur within your Progress Report, Treatment or Service Plan reporting periods will automatically show up no matter where you create them.

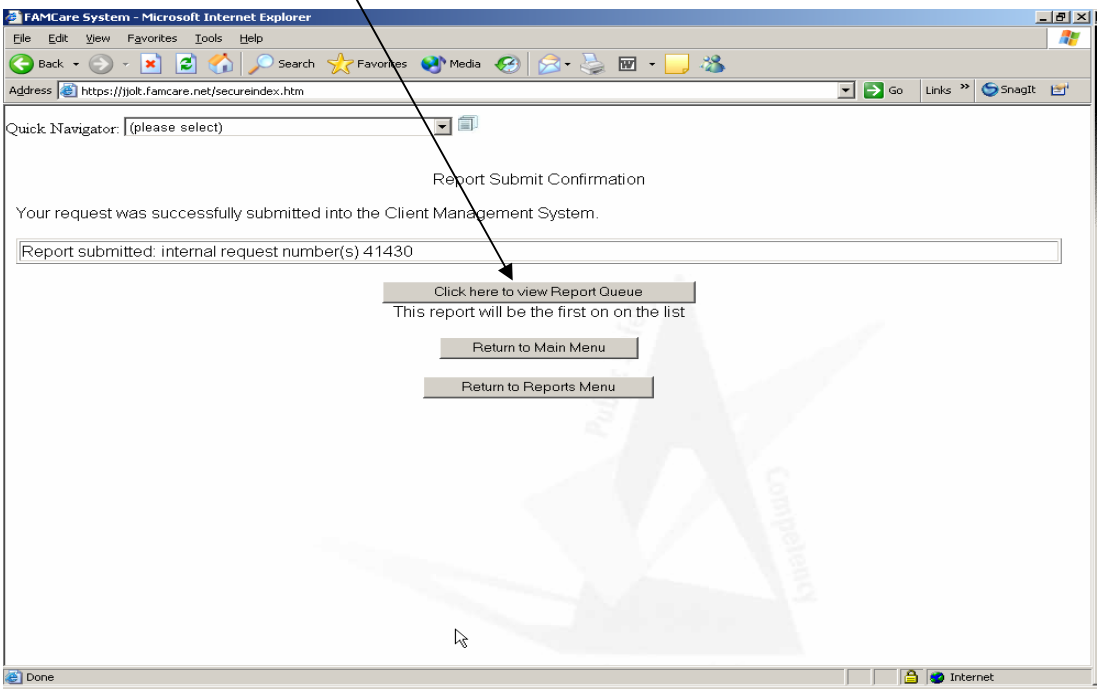
Printing and Case Note Report:

To obtain a case note report, go to the Quick Navigator and click on **Custom Report.** By clicking on 8A or 8B, you can run a report according to placed and non-placed clients.

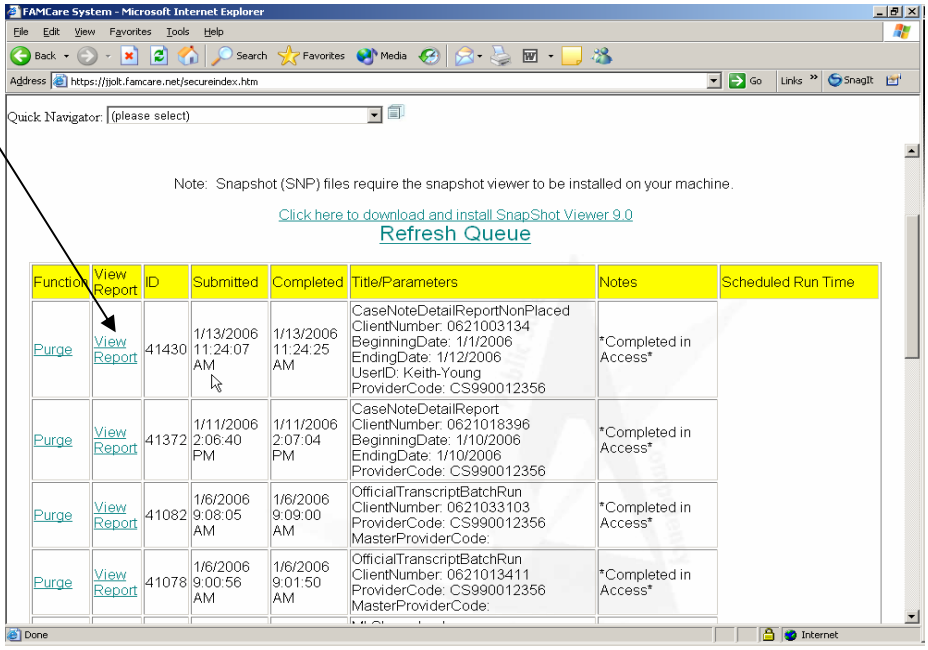


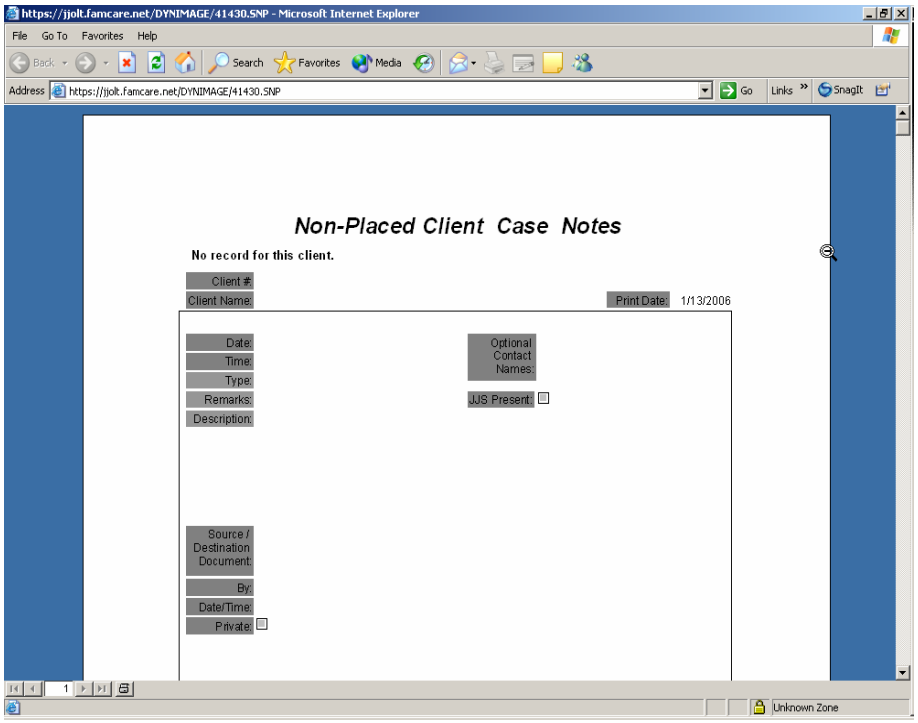


Place in a client number and desired date range, and then submit report. You will be able to view the report from your report queue, see below.



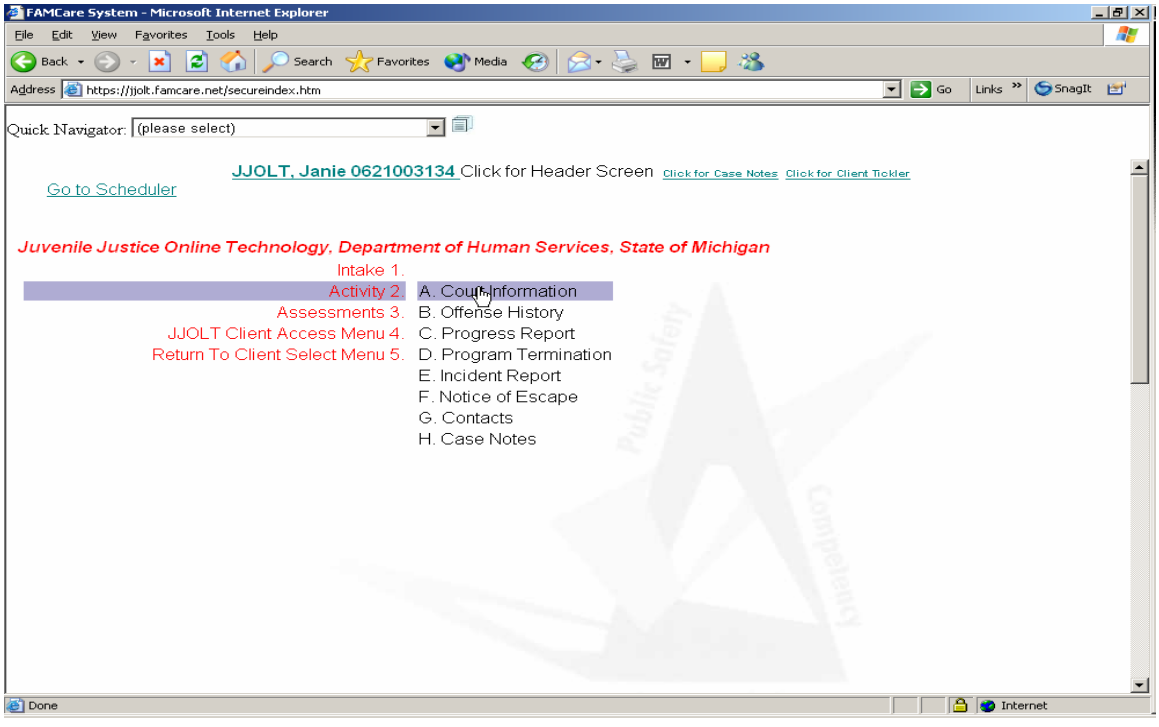
Once the report is completed in access, click on review report to access and print case notes. Please examples below.

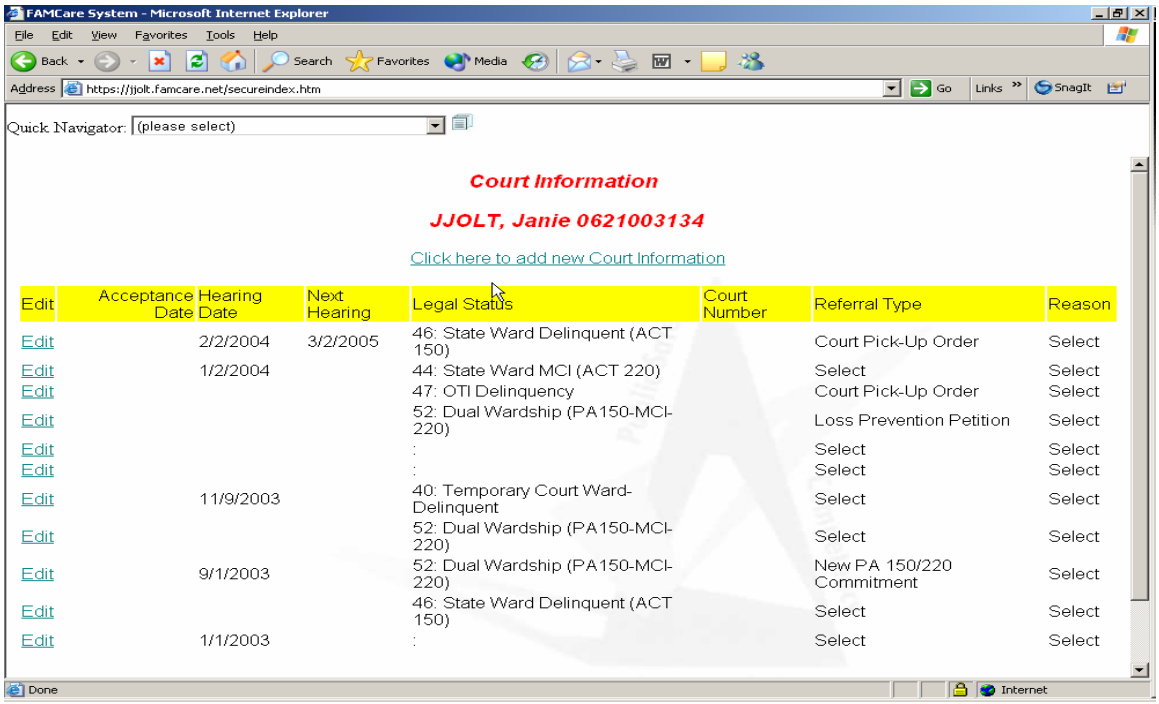




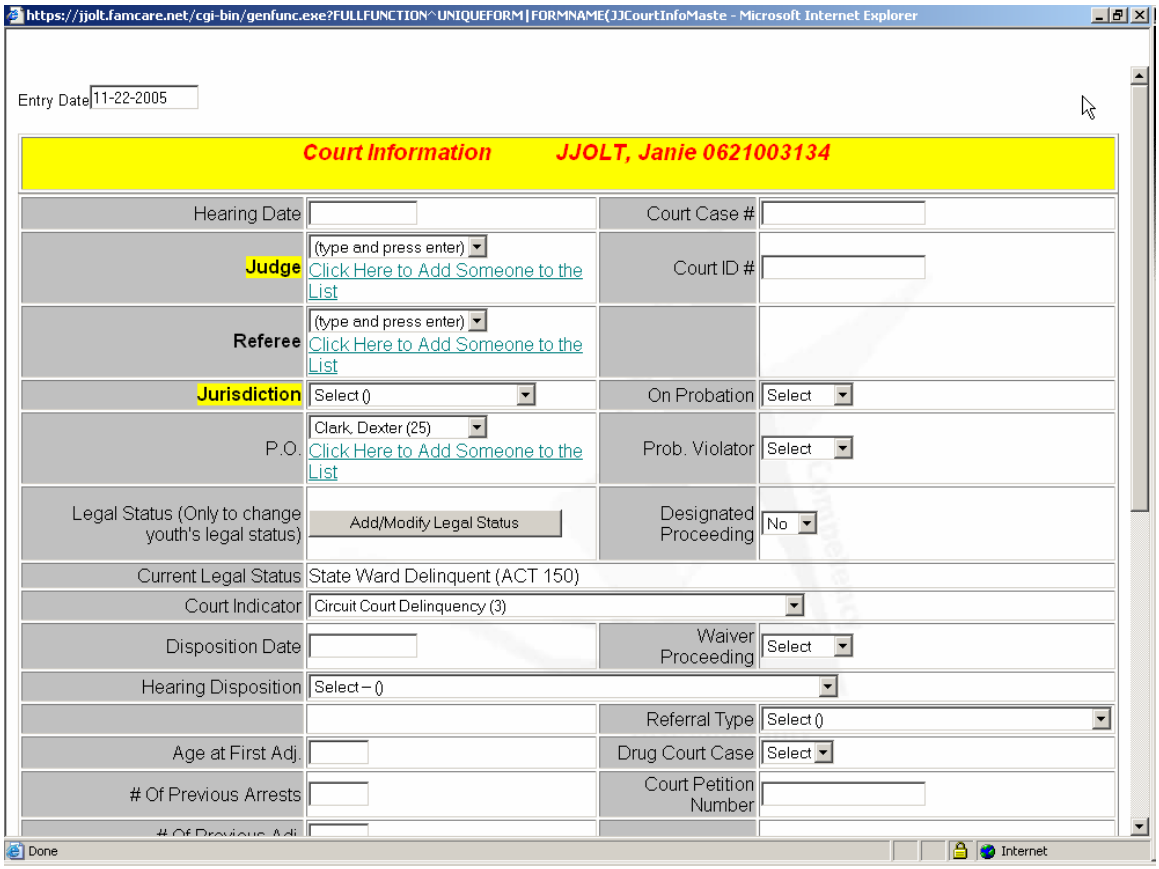
Court information / Petition

Each time there is a Court Contact within your county, you can complete a Court Information Form from 2A on the forms menu.





When accessing the Court Information form, you will come to the Summation page including previous reports. You can access these forms by clicking the Edit button. You also can create a new form by clicking Click here to add Court Information. .This will bring up the following form.



Fill out the form accordingly, including information in the areas shaded in yellow. Please see the Dynamic Entry section of your Manual. Save your information by clicking the save button at the bottom of the form, and close and refresh your data.

Session II – Progress Reports

Progress Report

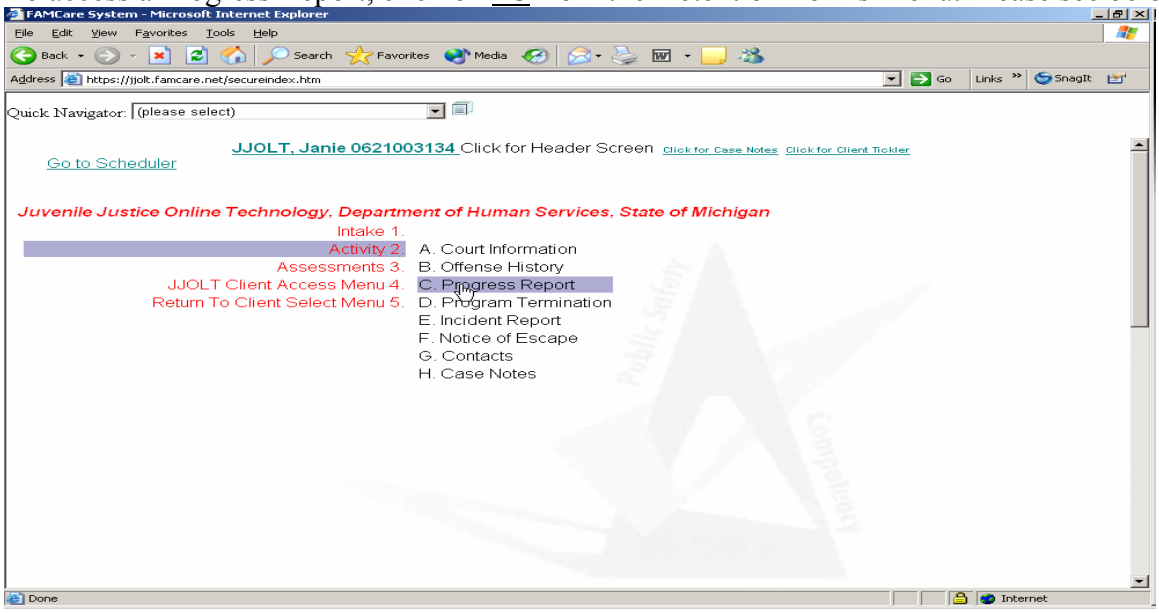
To begin, when you first start a JJIS Progress Report for a youth, even if you are starting with an Updated Progress report, (for a youth that has been in your program for some time) you will "Create a New Form". When this opens you will be requested to "select a form" Initial, Updated or Interim. Initial reports are due on the 7th day after admission. Updated reports are due on the 21st day. Interim reports are due 15 days after the updated. The updated and interim reports will alternate every 15 days until release. Select the appropriate choice **then hit your TAB key**. This will set your form. Check your admission dates. If you are starting with an Initial Progress Report, your Admission Date and Report Start Date should be the same. Your report periods and days in care will automatically calculate by Tabbing through form. Now this should look just like the current Word documents we use at FIA. Add information to your Progress Reports as you normally would.

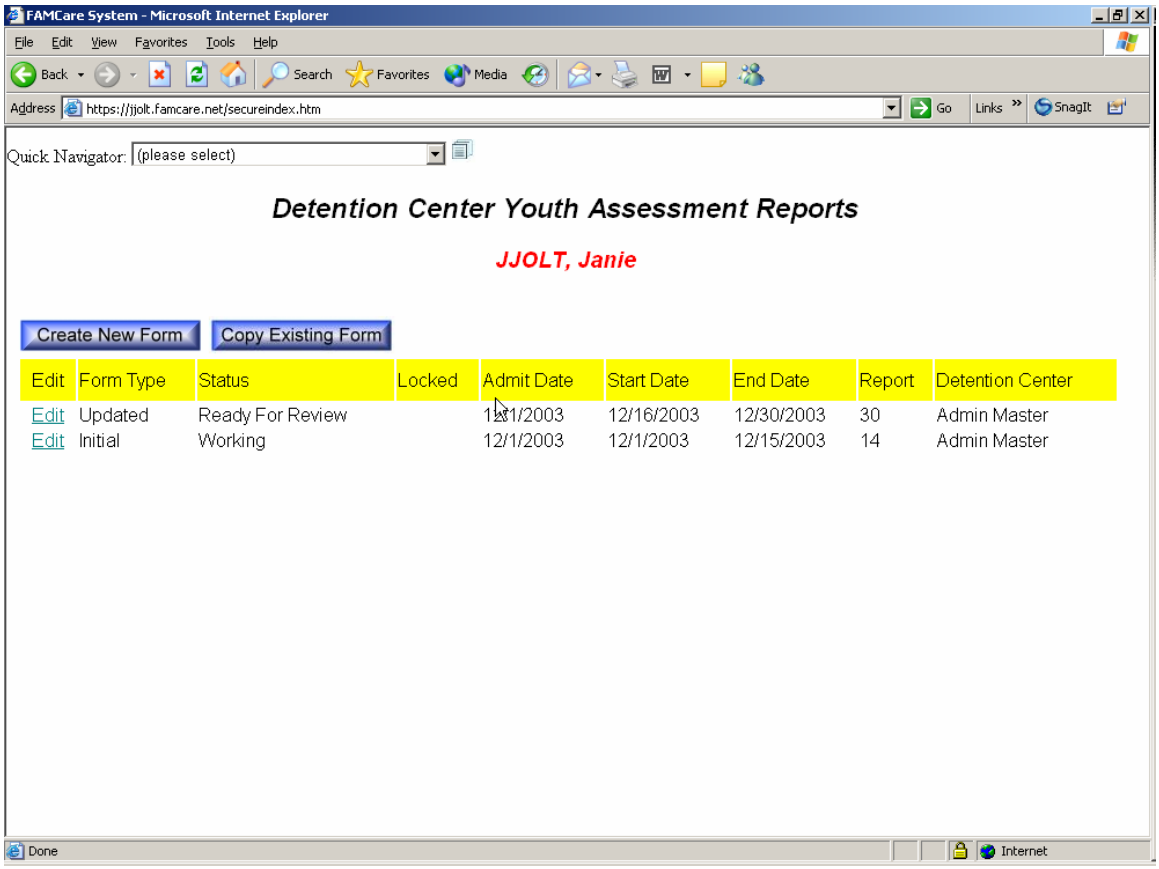
When you are finished, if you have an appointment, or whenever you need to leave working on your Progress Report, at the end of the document you will see a box to select either "Working", "Ready for Review", "Approved" or "Return for Edit". As a Treatment Leader you will select either Working or Ready for Review, a Supervisor will select either Approved or Return for Edit. Once a Supervisor puts in their Signature (password), and clicks on "Approved" there will be no more edits able to be made.

As long as you are working on a report, every time you want to open it up, click on the ***Edit*** button next to the report you are working on. When it has been finished and approved etc… for your next report you would then click on the "Copy Existing Form". It will bring up all your old data from your previous report but now you can make changes to it…Keep repeating until youth is discharged.

You must complete a termination report by selecting **4I** from the form menu. Answer the questions accordingly and save your information.

To access a Progress Report, click on 2C from the Detention Forms Menu. Please see below.





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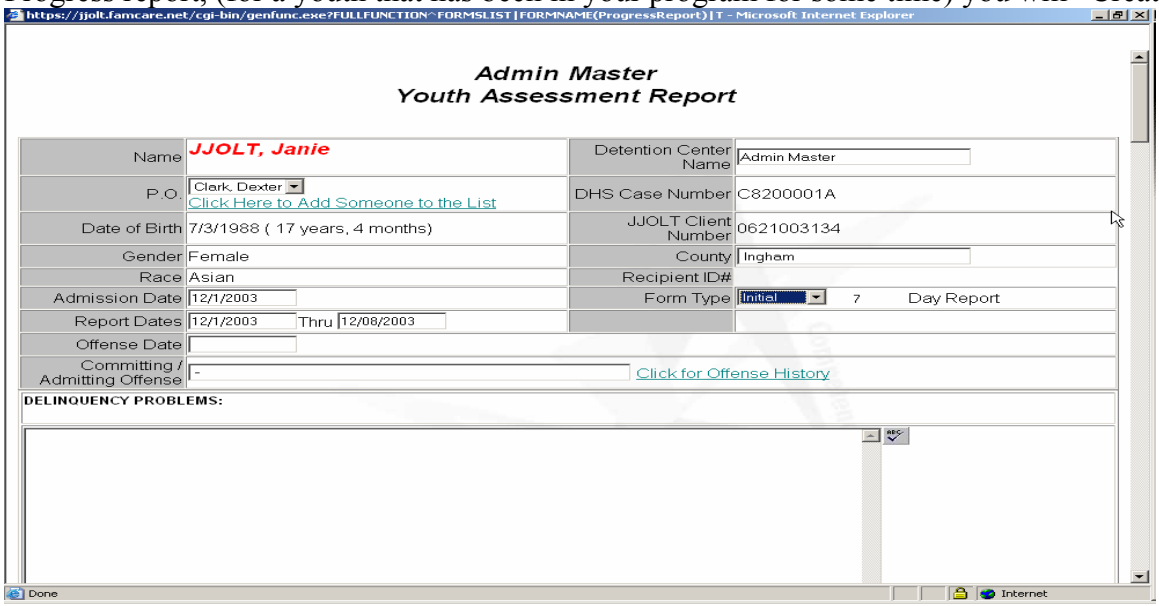
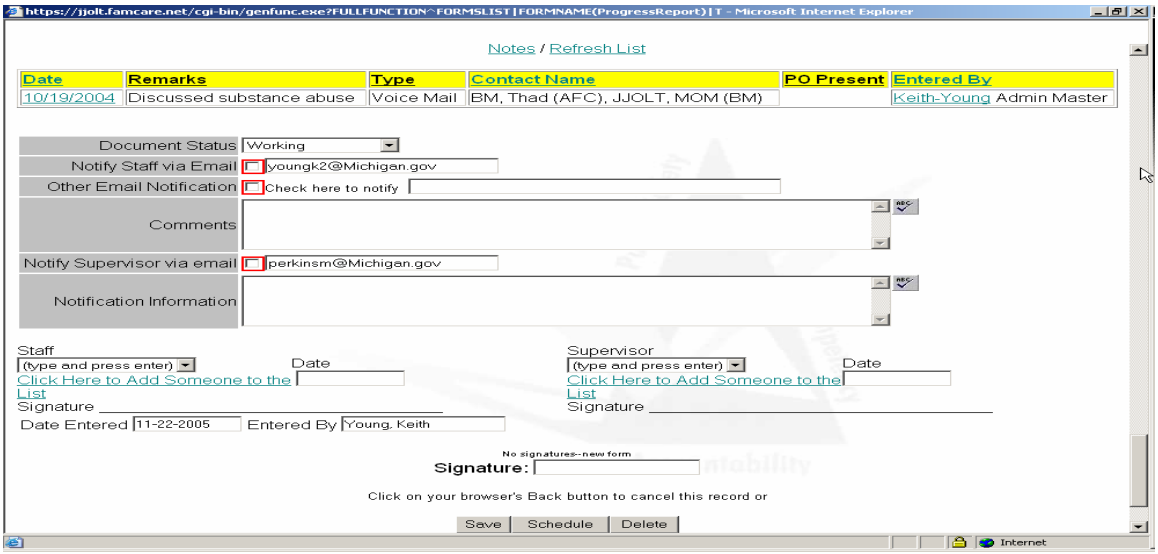


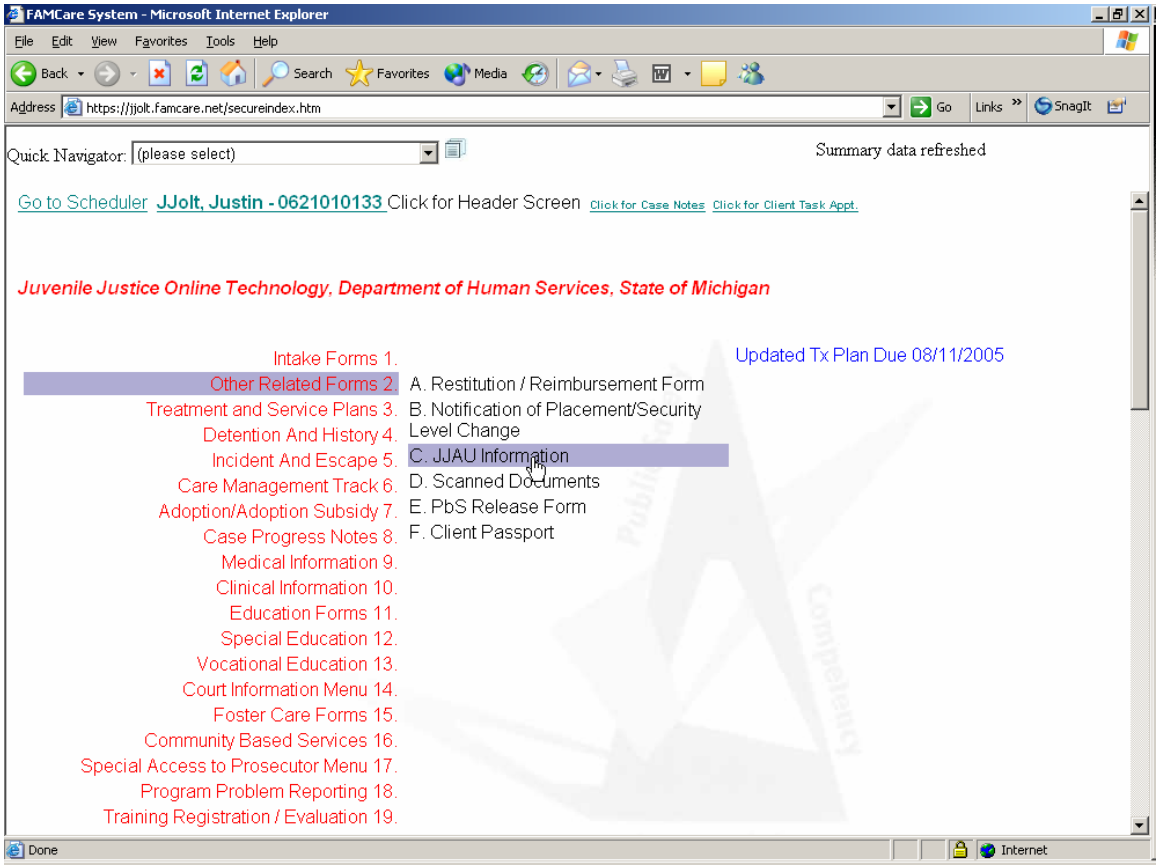
Each text box has a brief description of what needs to be addressed, and also spell check. There is also a section that will pull your Case Notes for the report period, when creating your case notes you must select Progress report as your source destination.



Please see working, Ready for Review, and Approval process mentioned above

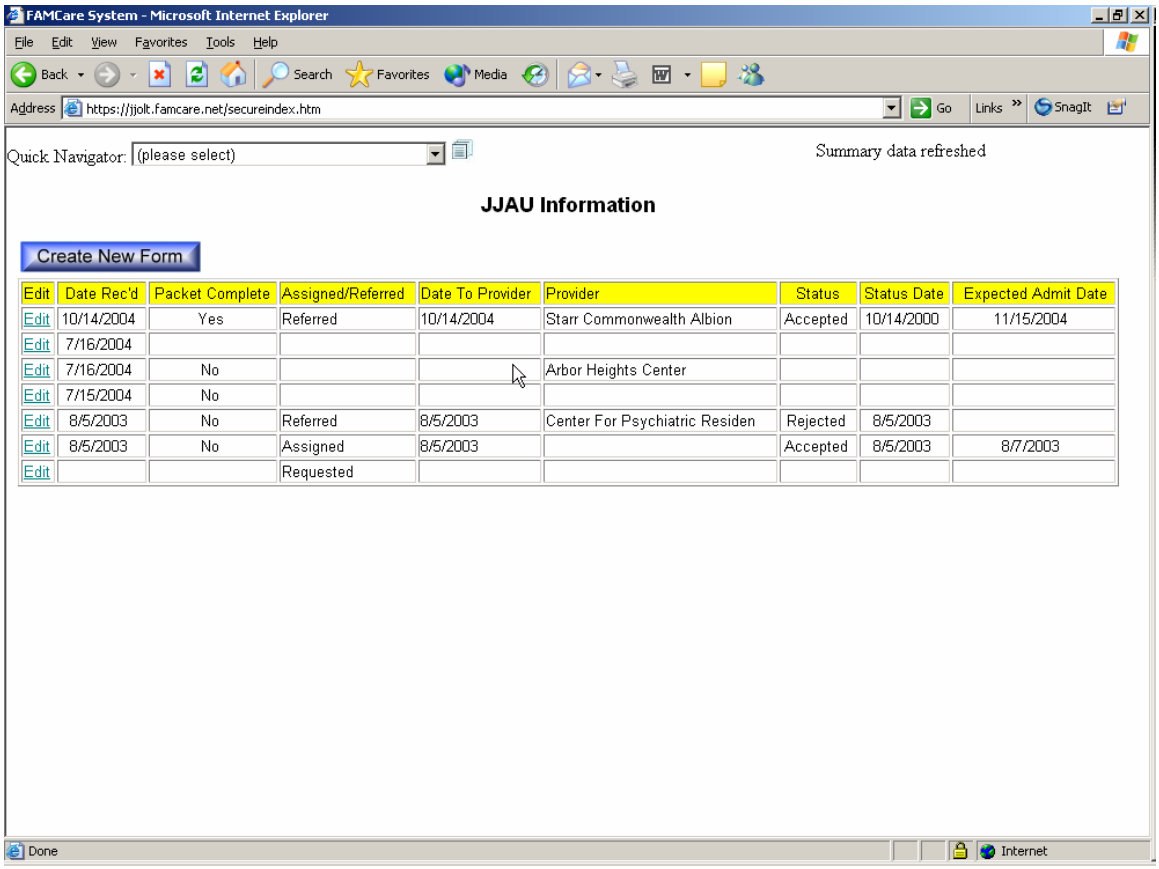
JJAU Referral / Acceptance Procedure

JJAU will send out a referral to each provider according to provider grids matching court ordered possible placements. When you receive a referral, you will be allowed 7 to 14 days to view the case record for acceptance or rejection. Once you have reviewed the case record, you can notify JJAU electronically of your decision. You can access the JJAU information by going to the client's forms menu, and click on 2C.

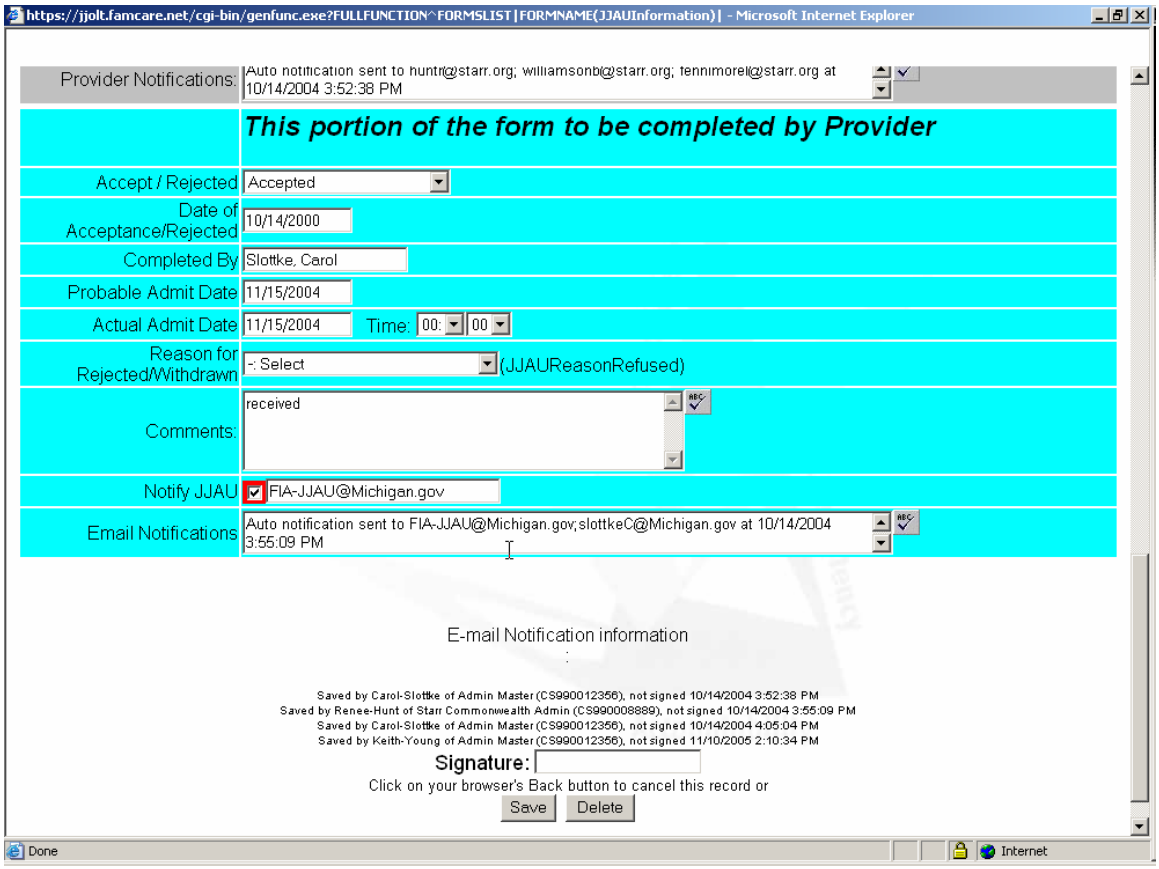


From the JJAU information screen, you can click on the edit button to enter.

Please see next page



Scroll down to the section for Providers and fill in the necessary information. If you choose to accept, and when the client is actually admitted to your facility, please put in the actual admit date. Place a check mark in the box to notify JJAU via E-Mail, and then click the save button at the bottom of page. Please see example on the next page



Once JJAU is notified that the client is at your facility, and actual admit date, the CMT will be created stating that the client is at your facility. You will not be able to complete Treatment Plans if this process is not completed.

MICHIGAN DEPARTMENT OF HUMAN SERVICES

Bureau of Juvenile Justice

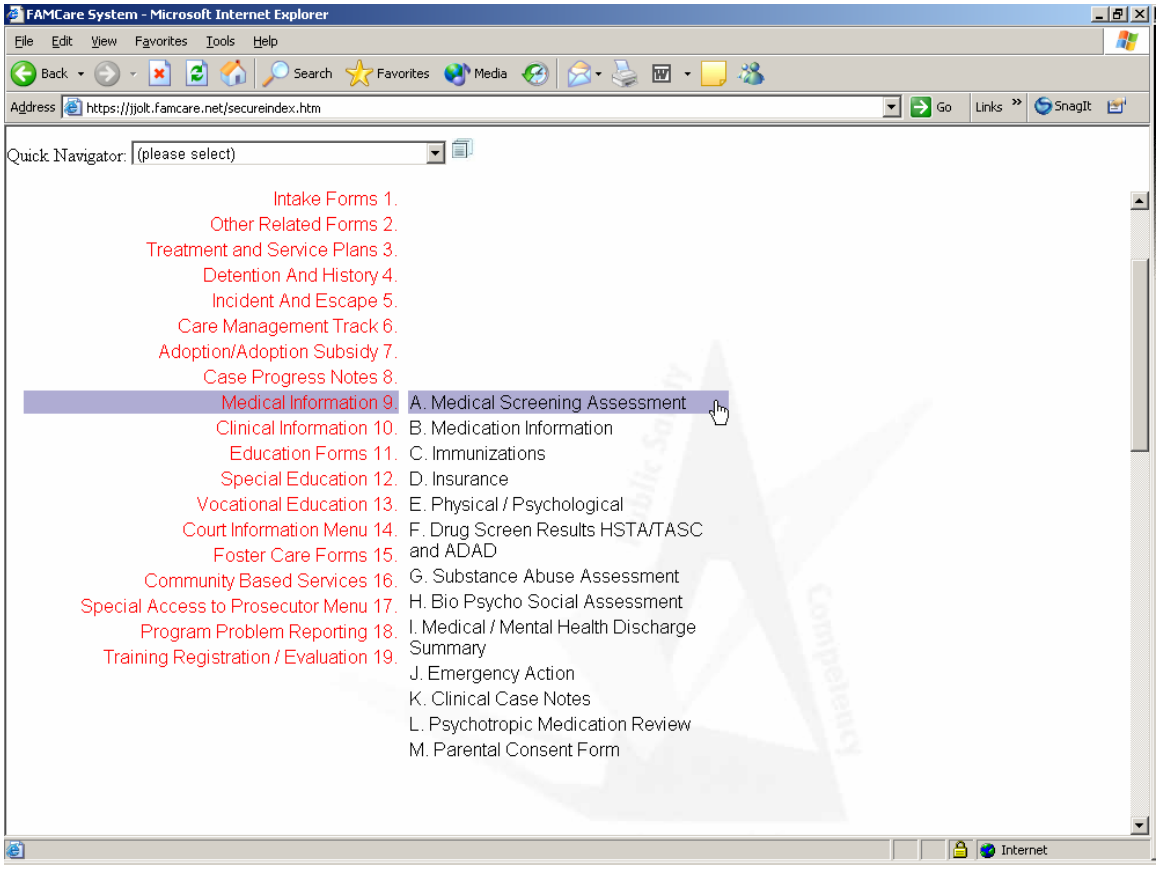
Medical Information Users Manual

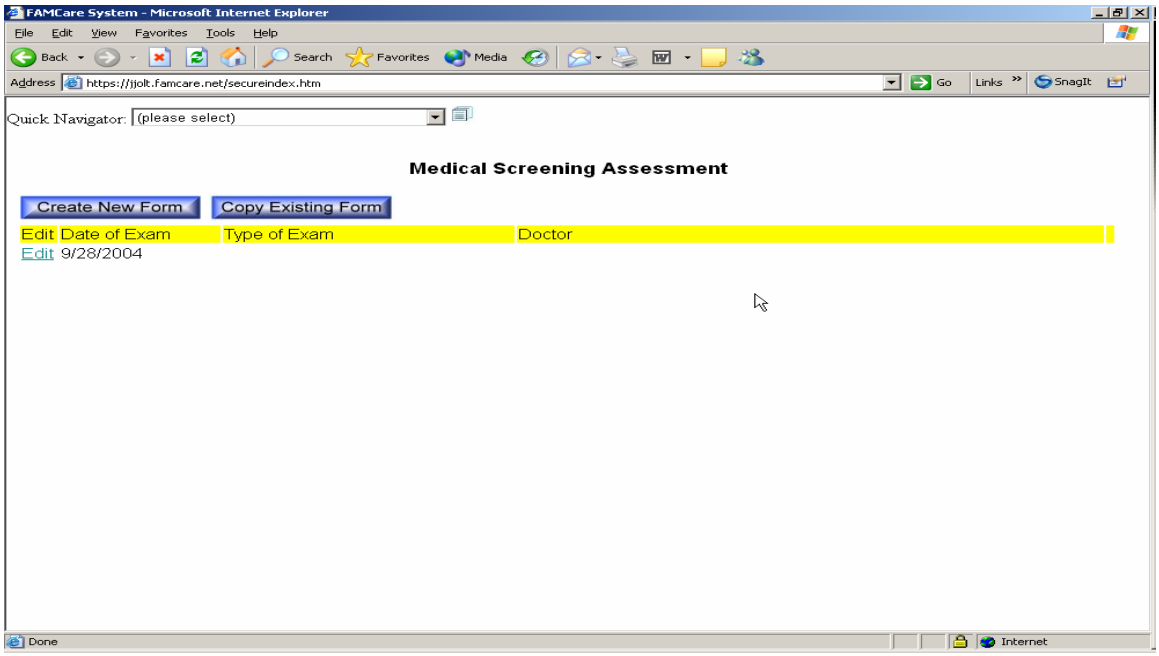
16 November 2005

DRAFT-FOR TRAINING USE ONLY

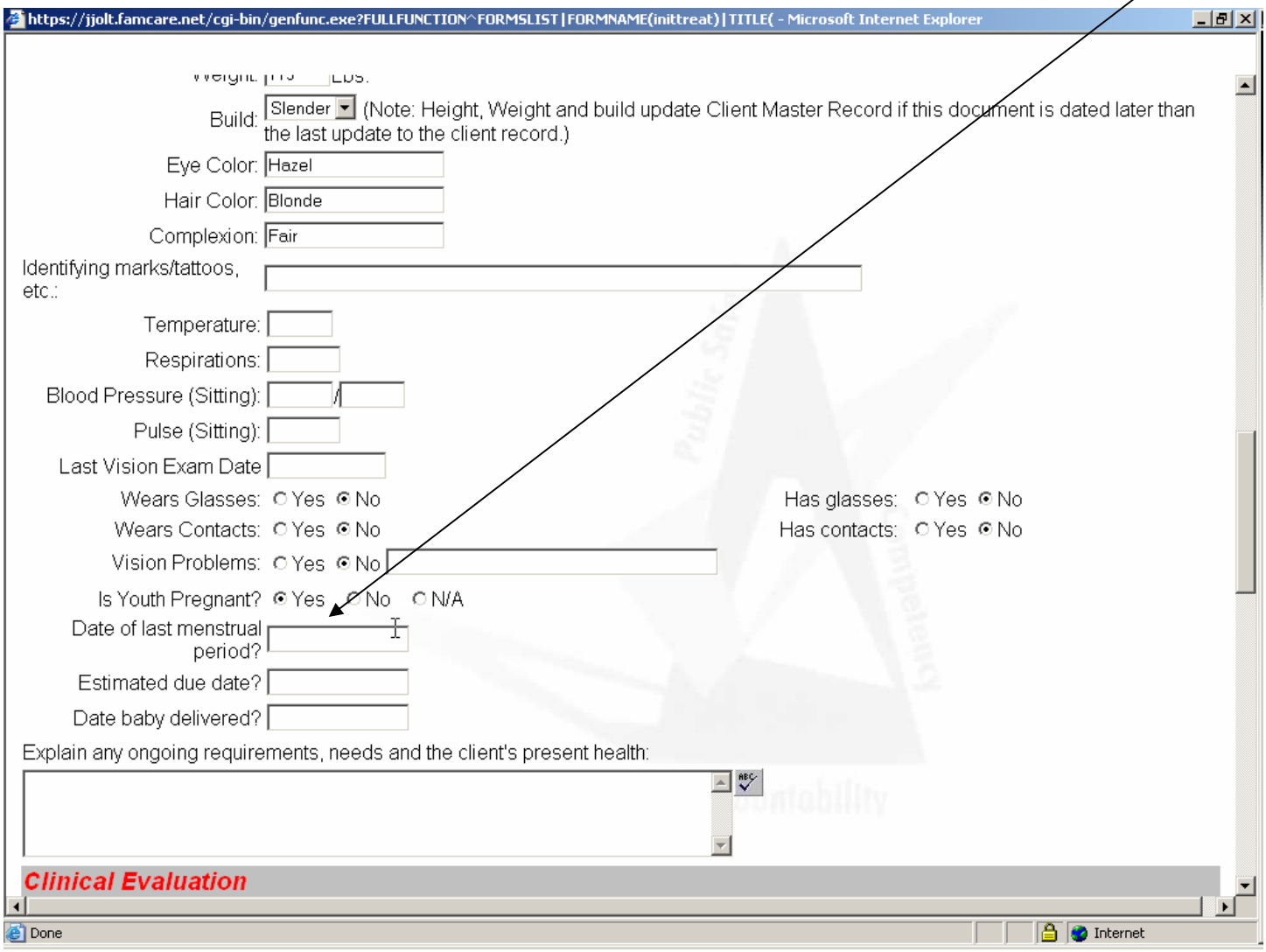
Medical Information

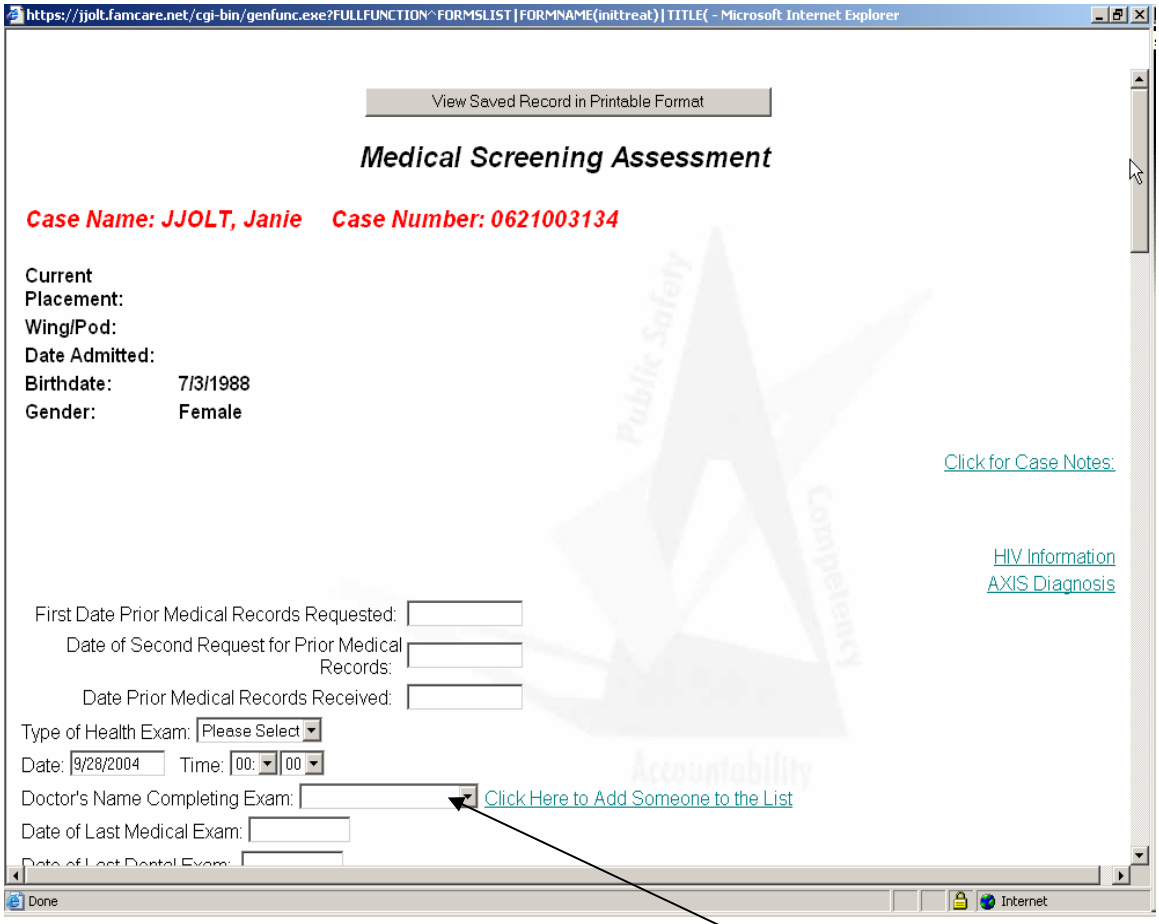
To access the Medical Screening Assessment, go to 9A on the client forms menu. You will then have the option to create a new form, or copy an existing. As always, when completing your initial report, you should create new. Each additional entry, it is best to copy existing. After completing your initial save, you will be able to continue working on the form by using the edit button.



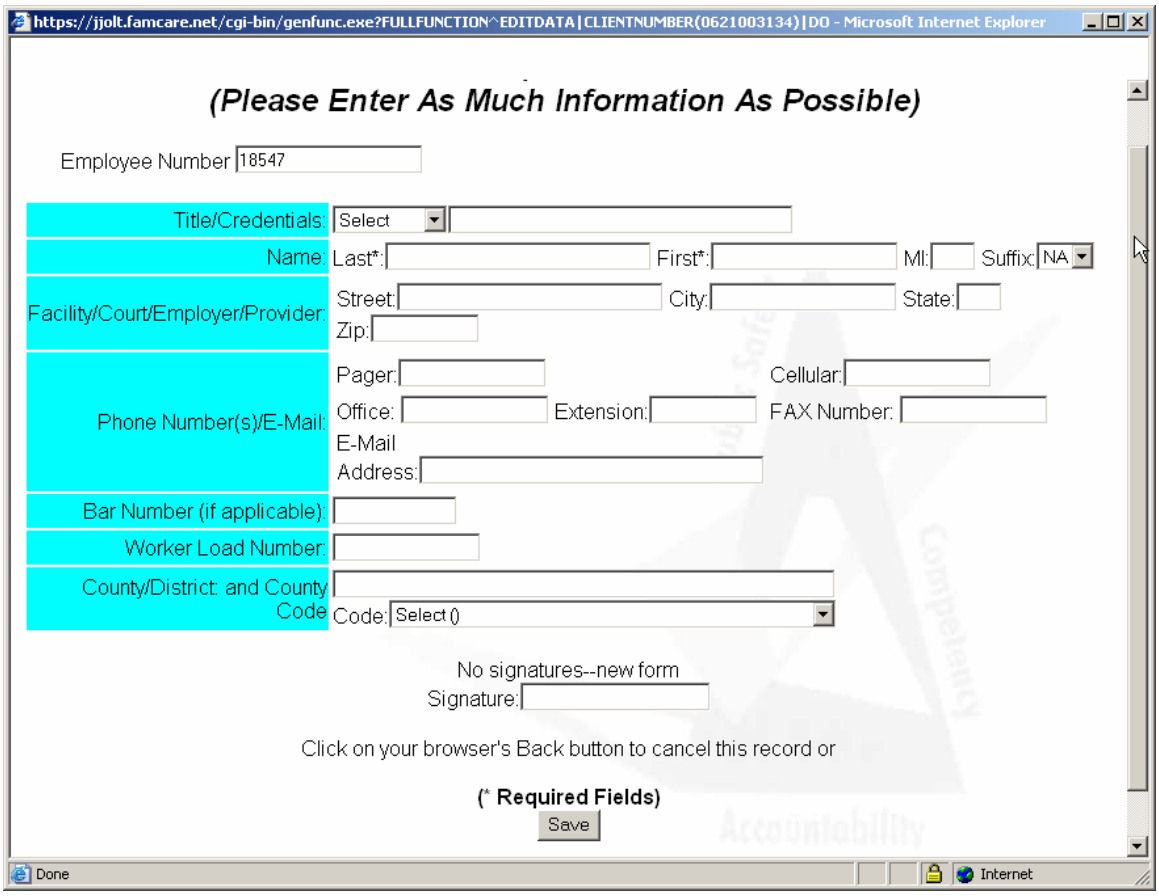


At this point you can fill in the information accordingly. If the client is pregnant please fill in the expected and actual delivery dates.

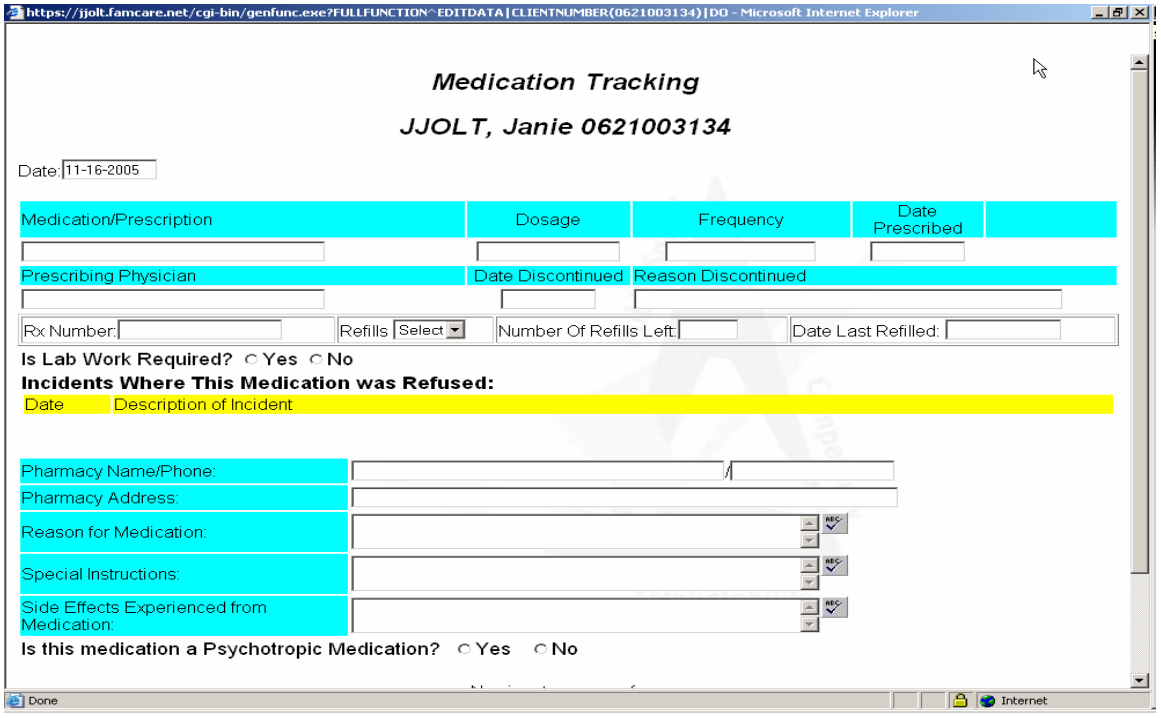




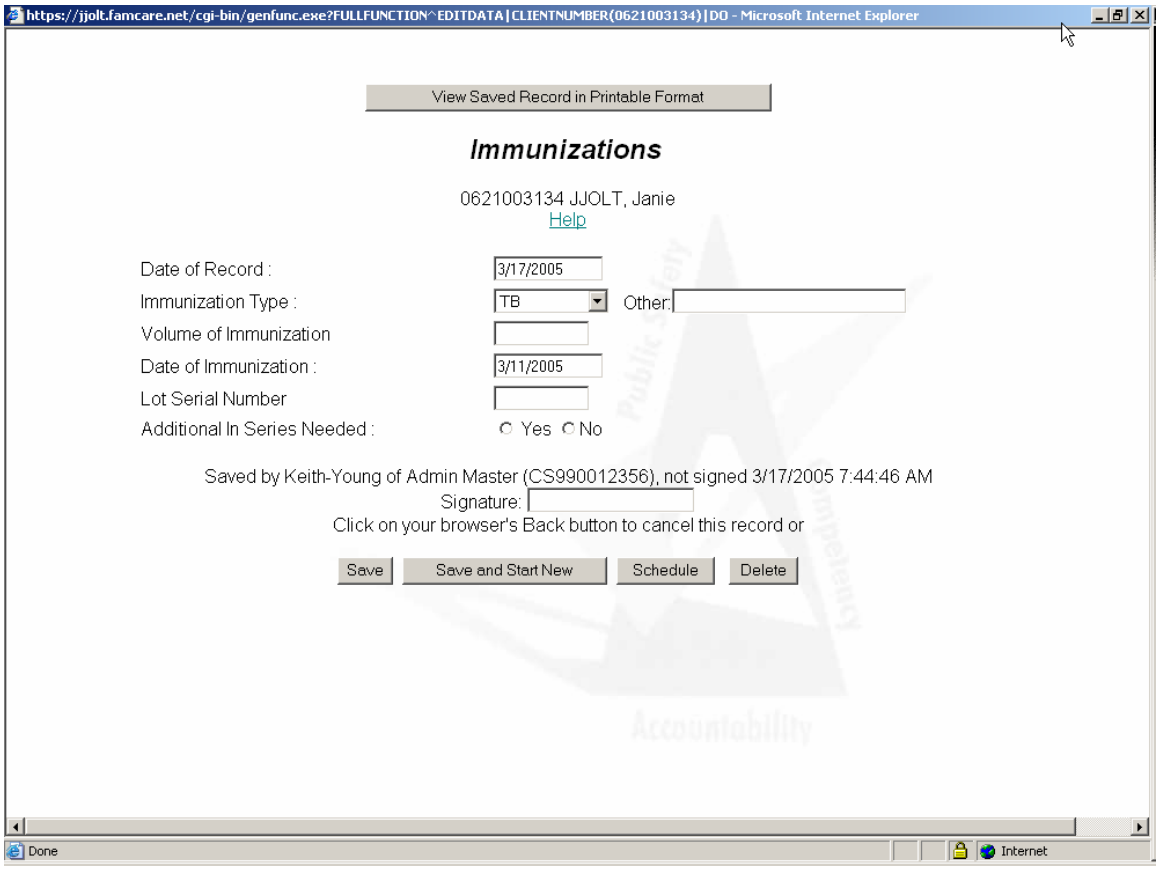
There is a Dynamic Entry feature available, which will allow you to add the name of Doctor completing the Exam. You must search for the Doctor by clicking within the text box to highlight Type and Press Enter. You must then type in the first three or four letters of the first or last name. This will create a list of names to select from, if the name you're looking for is not part of the list, the Dynamic entry feature will allow you to add someone's name to the list. You can accomplish this by clicking on the green link Click Here to Add Someone to the List. This will produce a screen where you can add the name and other pertinent information about that person. After completing your entry, you can save by clicking the save button at the bottom of the form. This only has to be completed one time, and the name will appear as part of the list when attempting additional searches throughout the system.



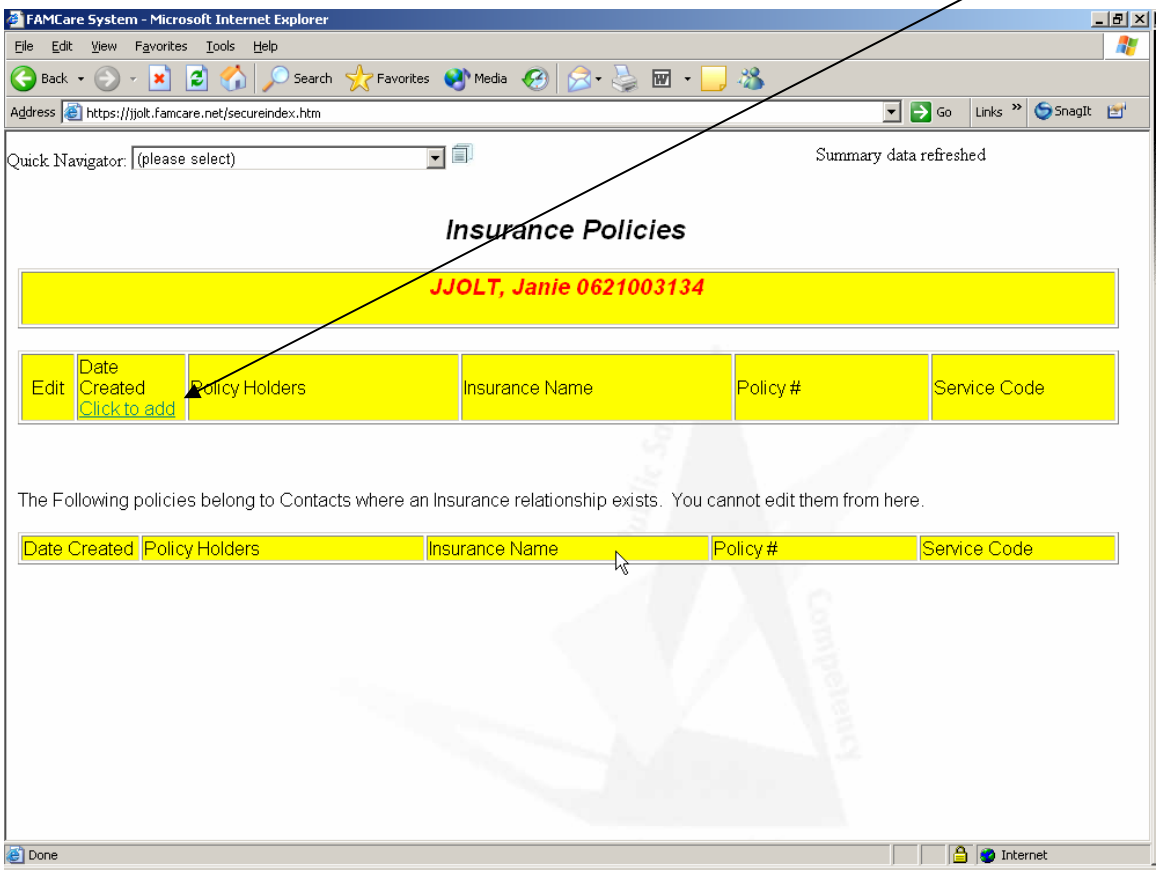
To enter Medication data, click on the Click here to add link located below Medications or you can access the same screen from 9B on the forms menu. You will be able to add the name of medication, dosage, begin and end date, Prescribing Physician, reason for the medication, etc. Once you have completed your entry, you can save by clicking the save button at the bottom of the form.



To enter Immunizations data, click on the Click here to add link located below Immunizations or you can access the same screen from 9C on the forms menu. You will be able to select date of record, immunizations type, volume of immunization, and other additional information as needed. Once you have completed your entry, you can save by clicking the save button at the bottom of the form.

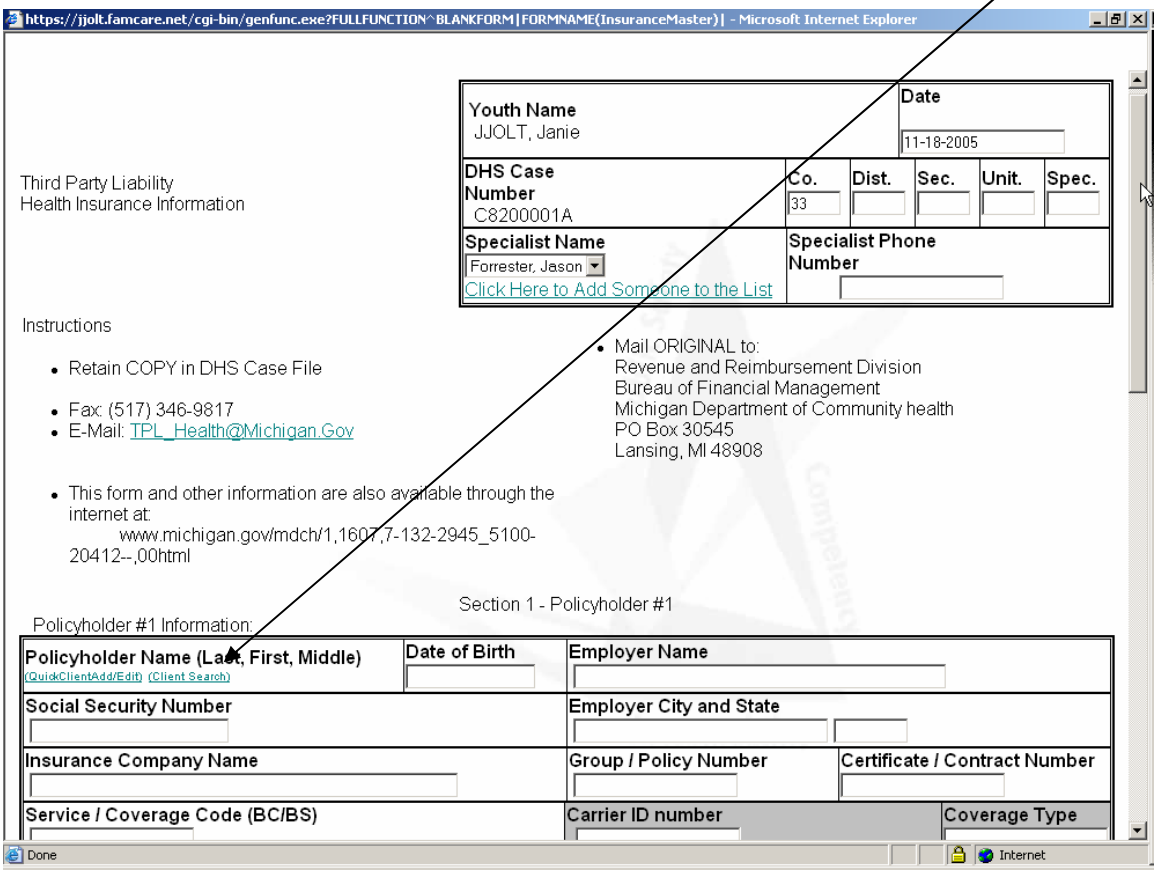


To enter Insurance data, you can access the initial screen from 9D on the forms menu. You will be able to view previously added forms, by clicking the edit button to the left. You can also create a new form by selecting the green link Click to add.

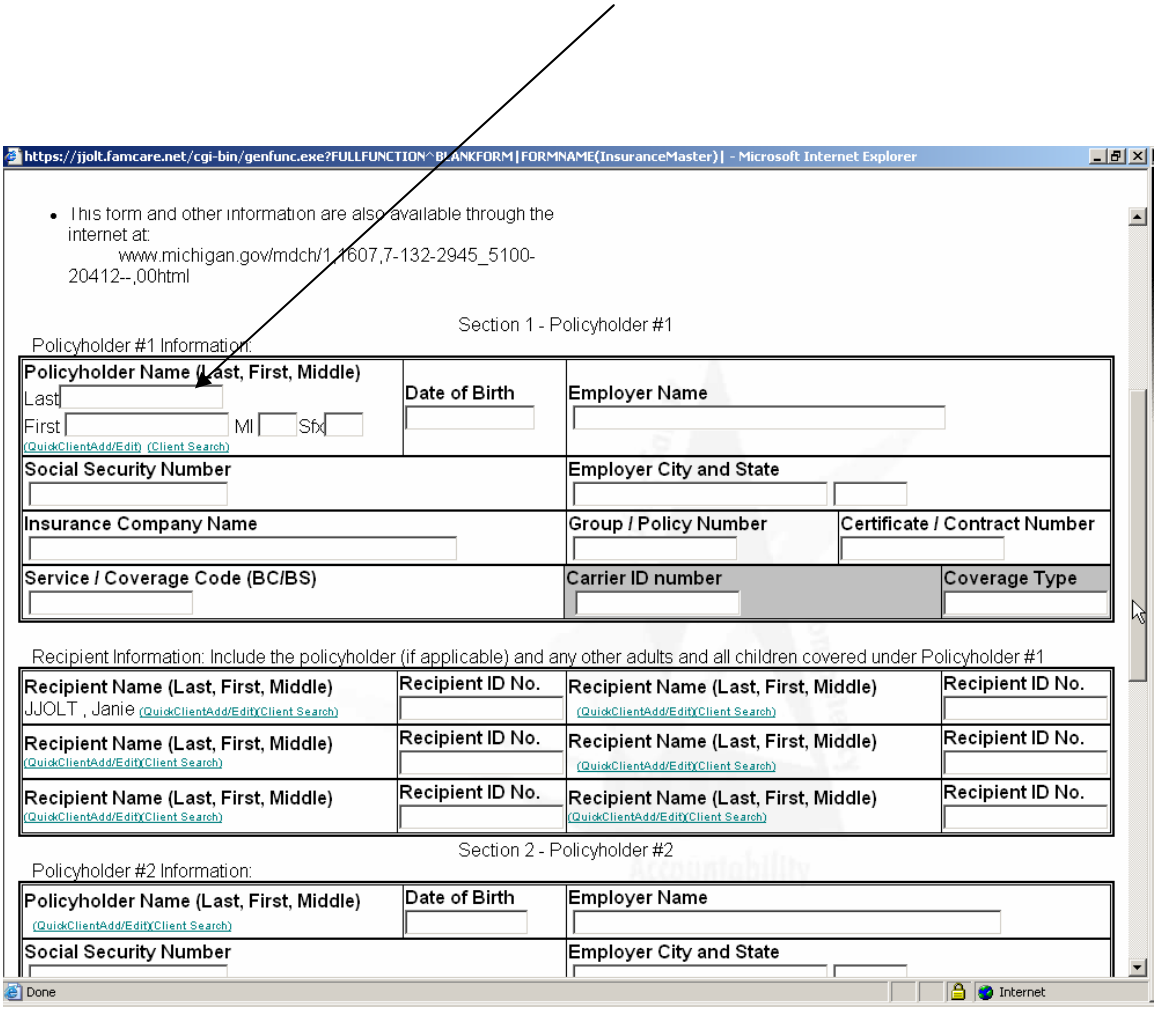


You will be able to add the name of the policy holder, 2nd policy holder, etc. Please see example on the next page.

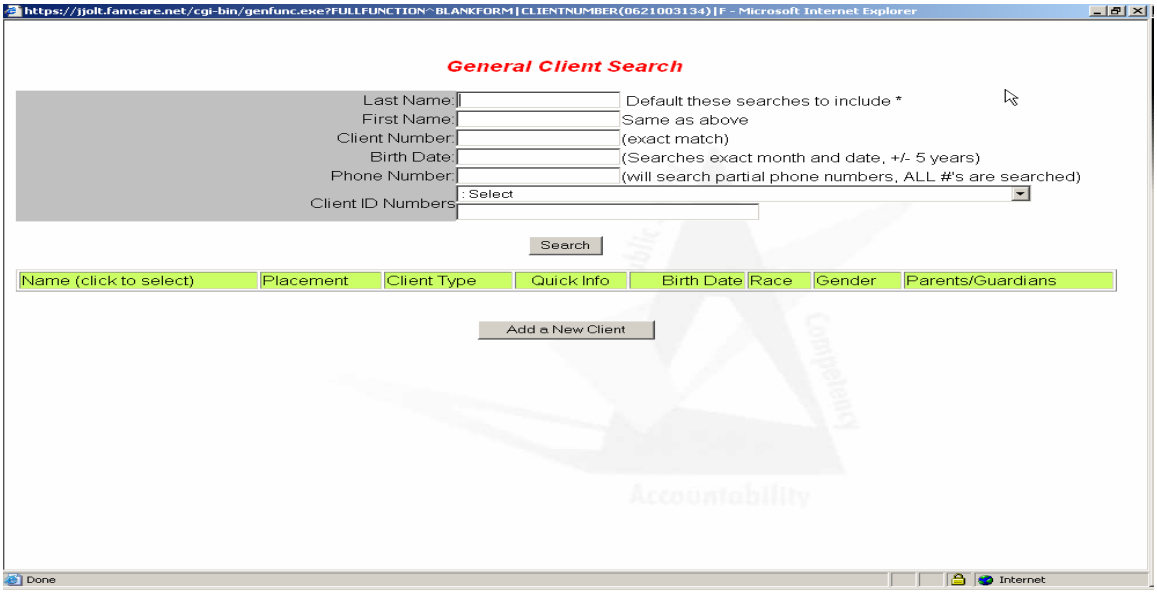
Please be aware when adding a name, the link allows you to complete three functions. Adding, editing, and searching for a name.

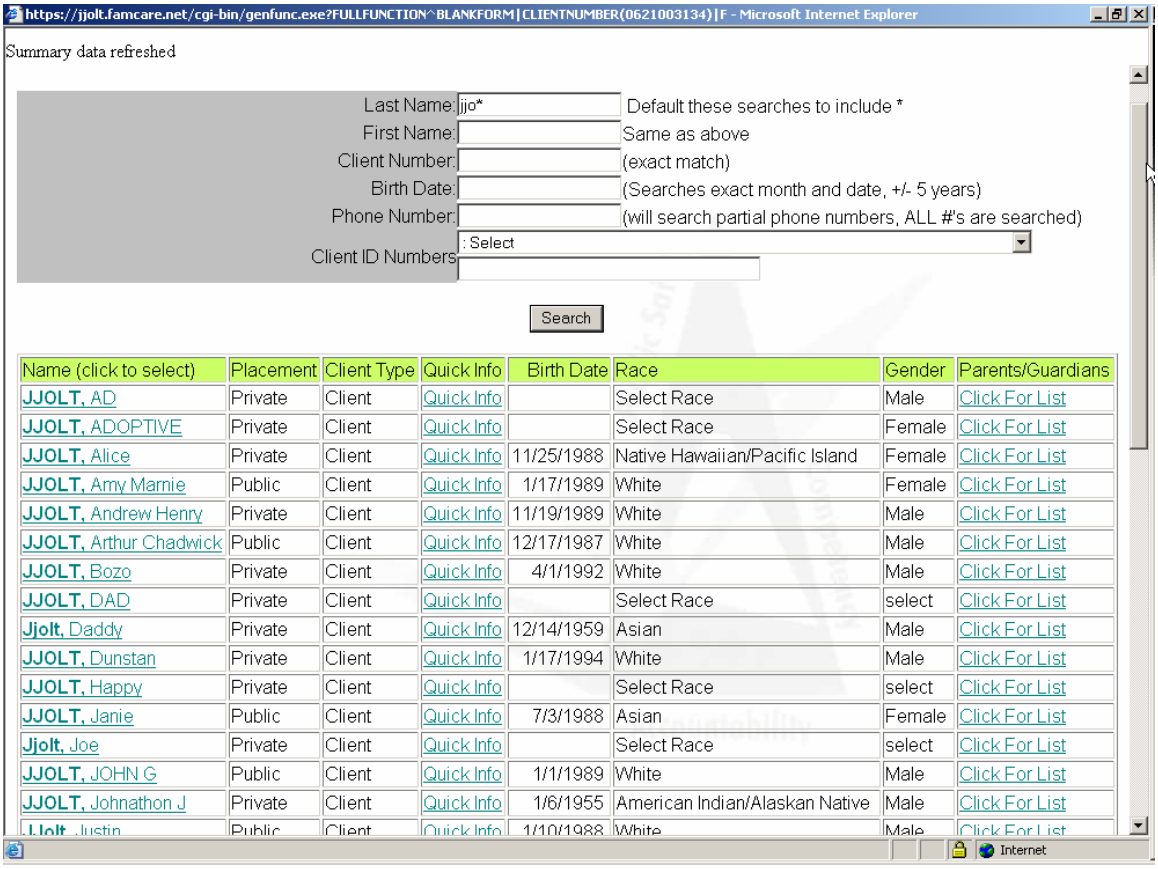


By clicking Quick client Add, you will be able to add the first and last name, along with other pertinent information.



Before adding a name to the form, you should search to see if that person is already in the system. You will be able to select their name from a drop down list after searching.

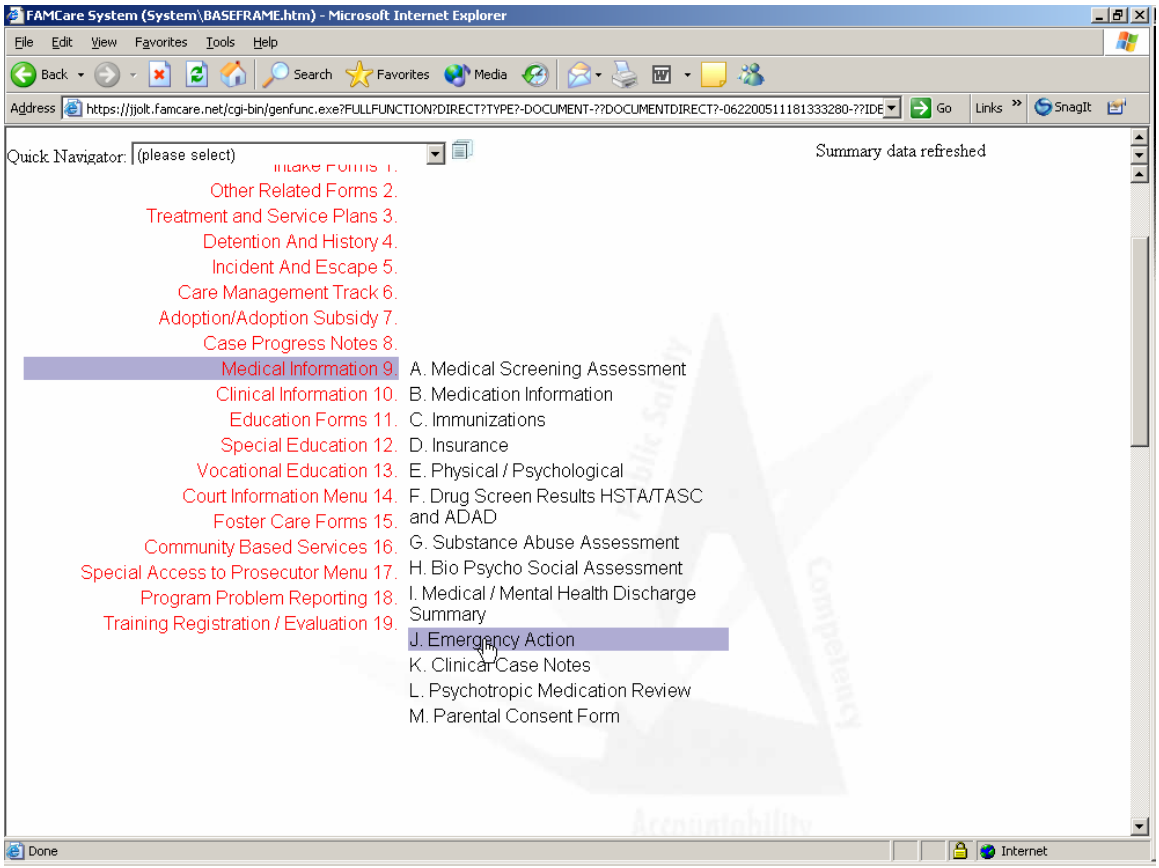




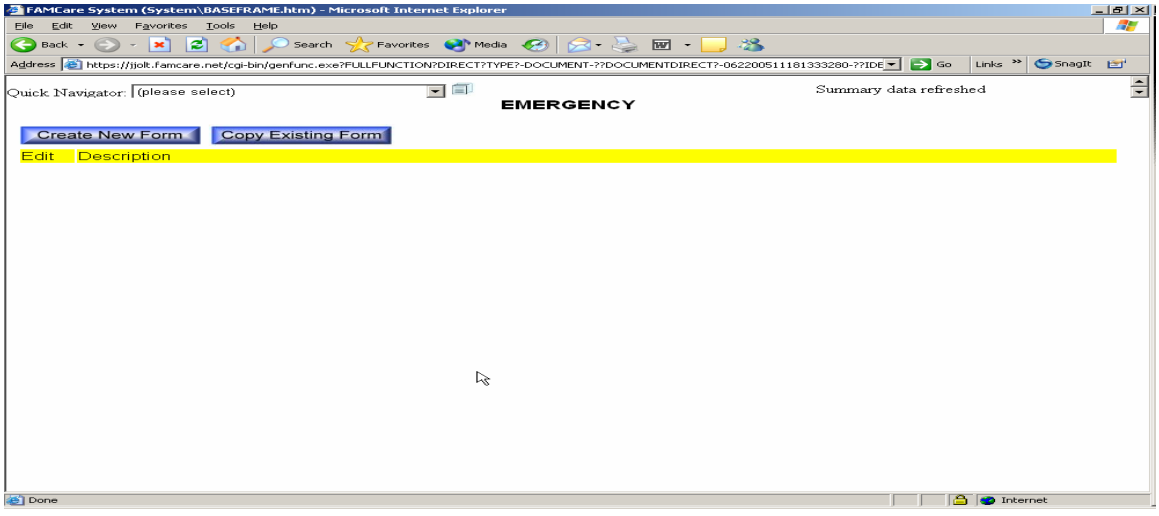
After entering all of your information, you can click the save button at the bottom of the form, and then close and refresh your data.

Emergency Action

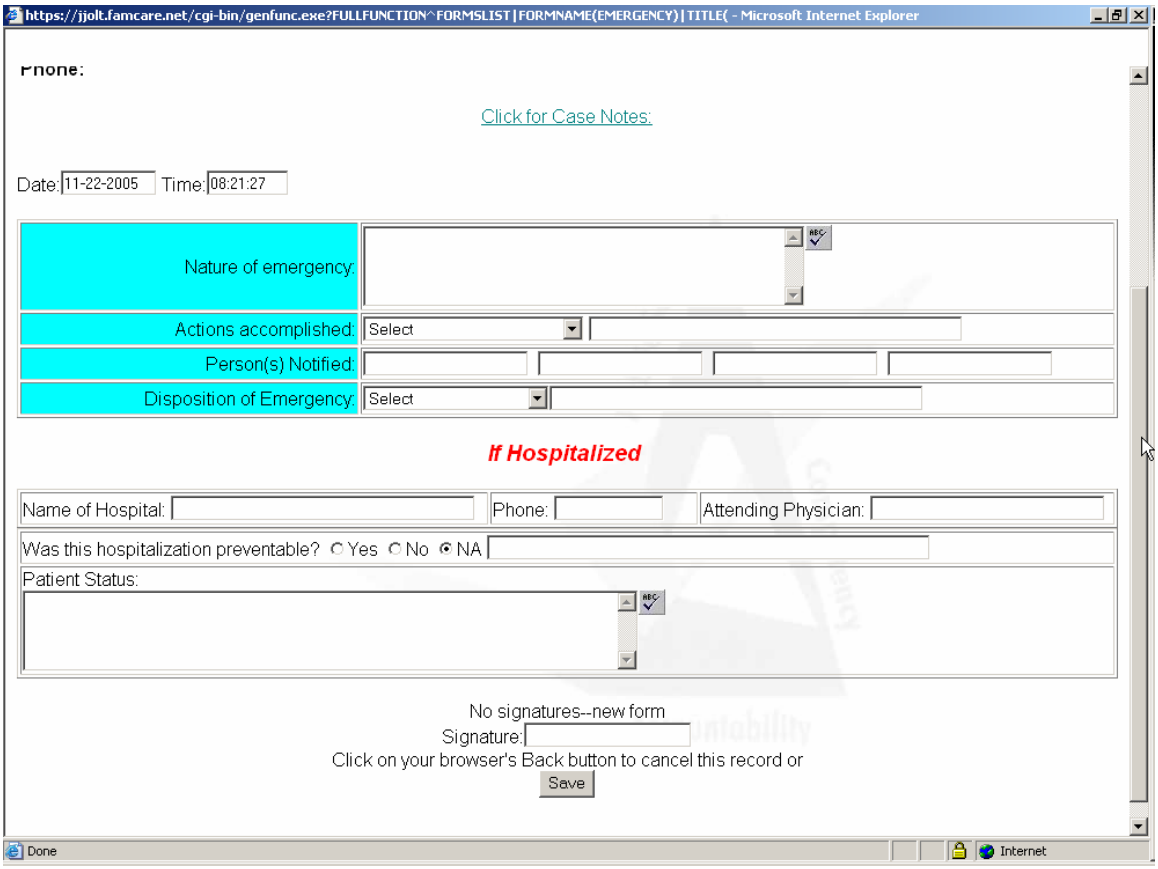
If Emergency Action is required, you can access the form through 9J on the forms menu.



You will have the option to create a new or copy existing.

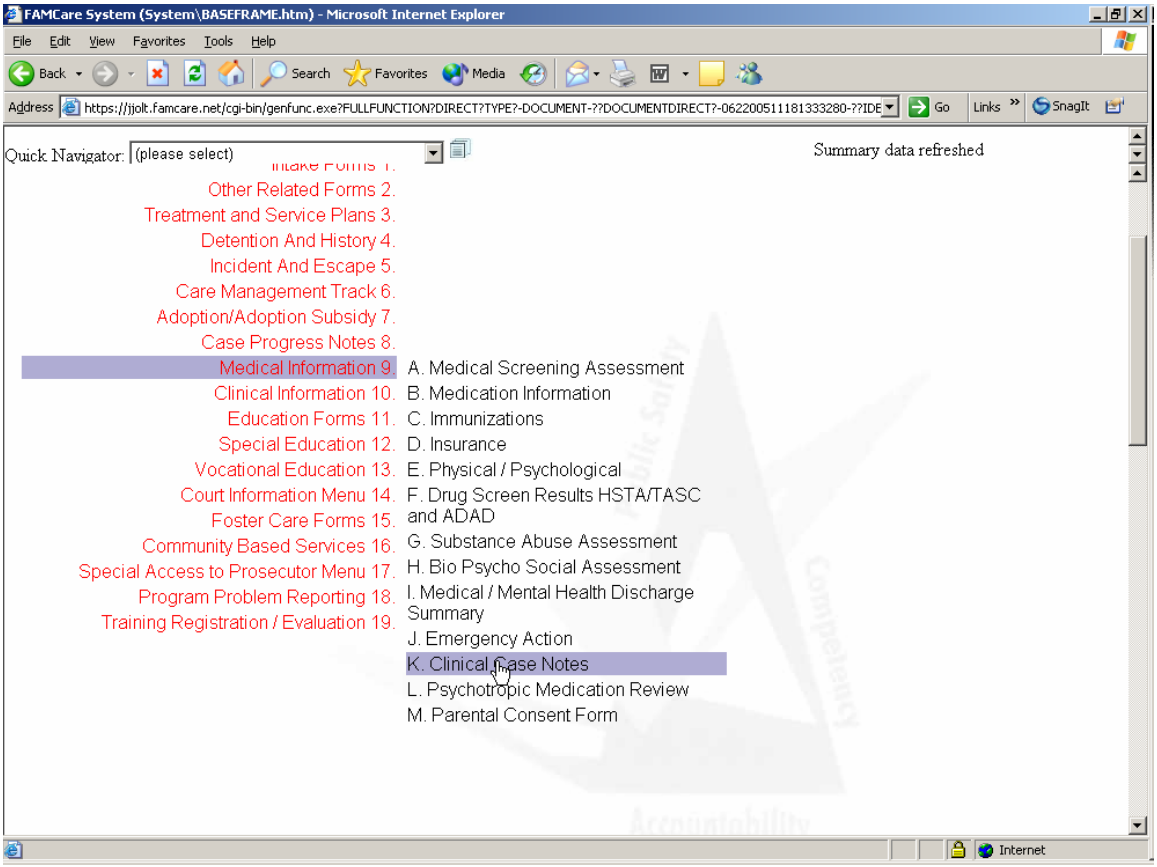


After completing you information you can save by clicking the save button at the bottom of the page.



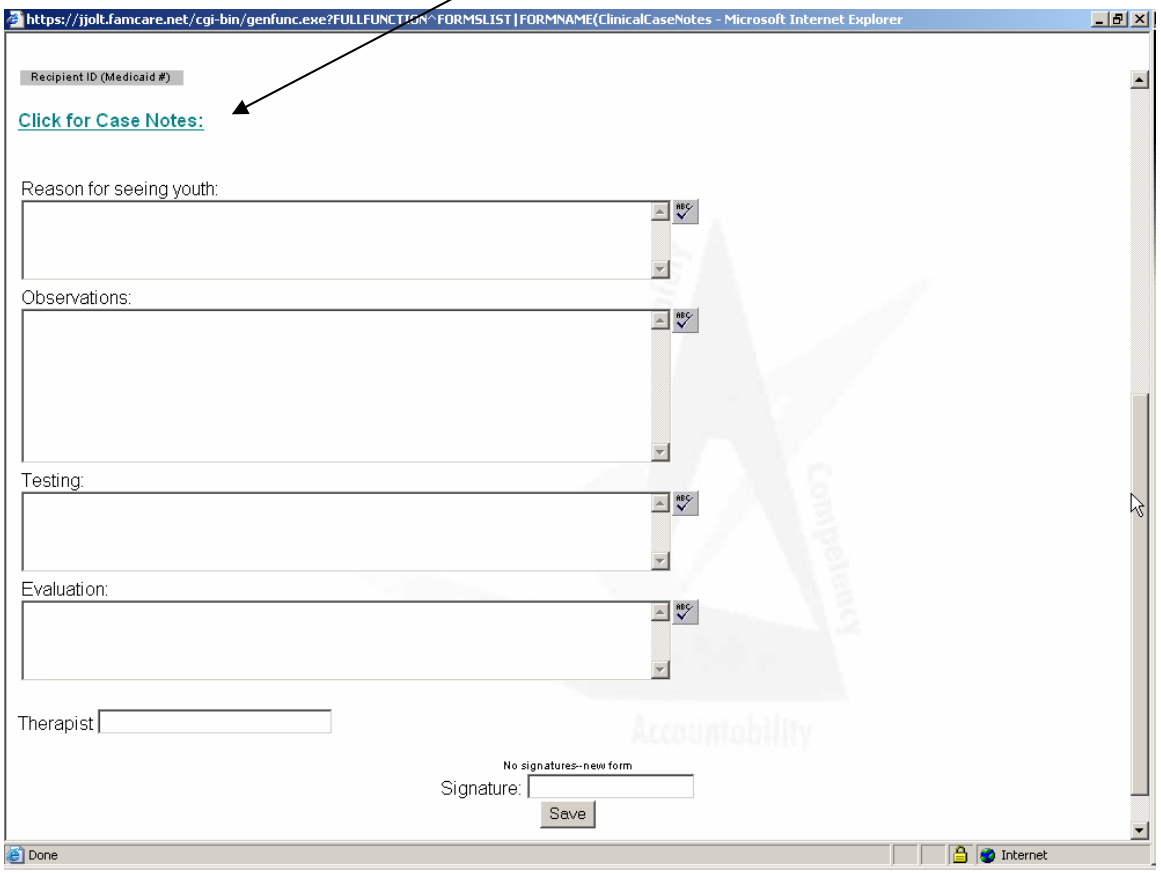
Clinical Case Note

To enter a Clinical Case Note, click on 9K from the forms menu, you will have the option to create new or copy existing.



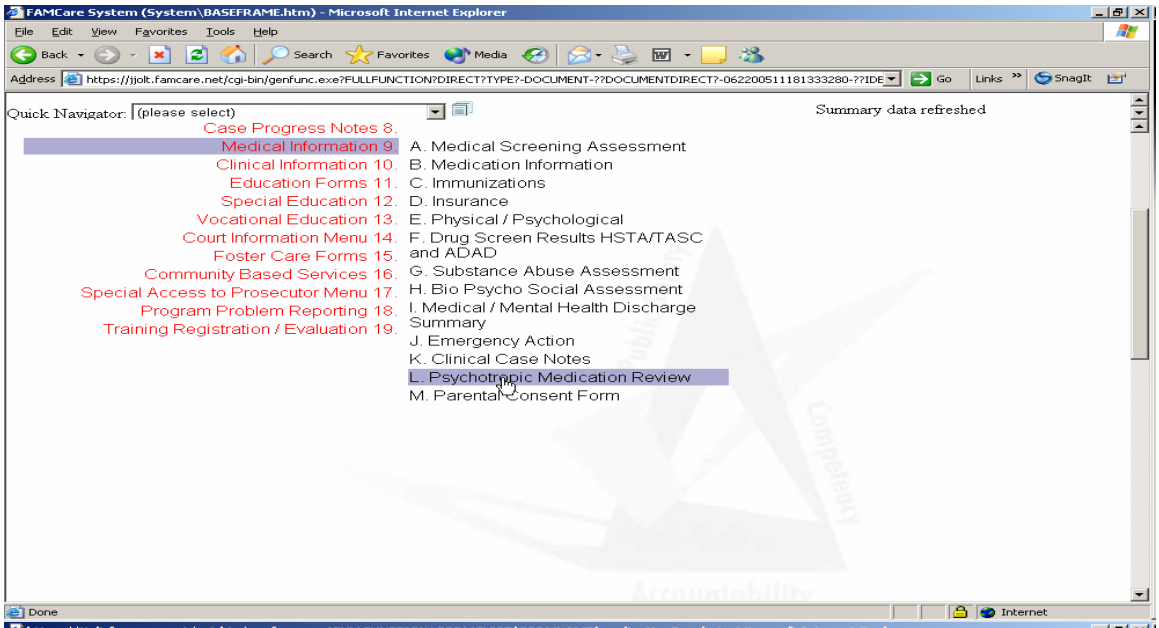
Click the save button at the bottom of the form to save your information, then close and refresh your data. This will also bring you back to summation page of Clinical Notes, to access each note click on the edit button. Please see next page for example of Clinical Case Note Form.

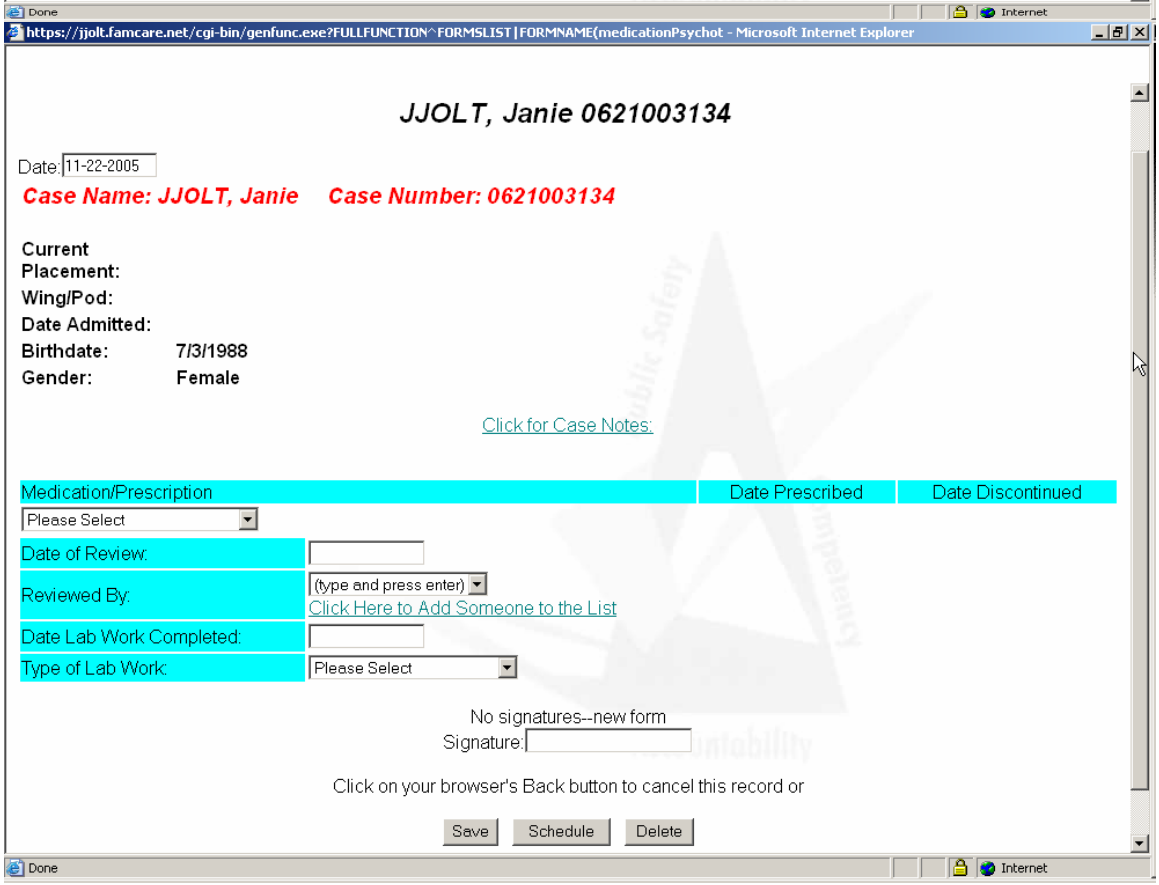
You will also be able to add a basic Case Note from the link below.



Psychotropic Medication Review

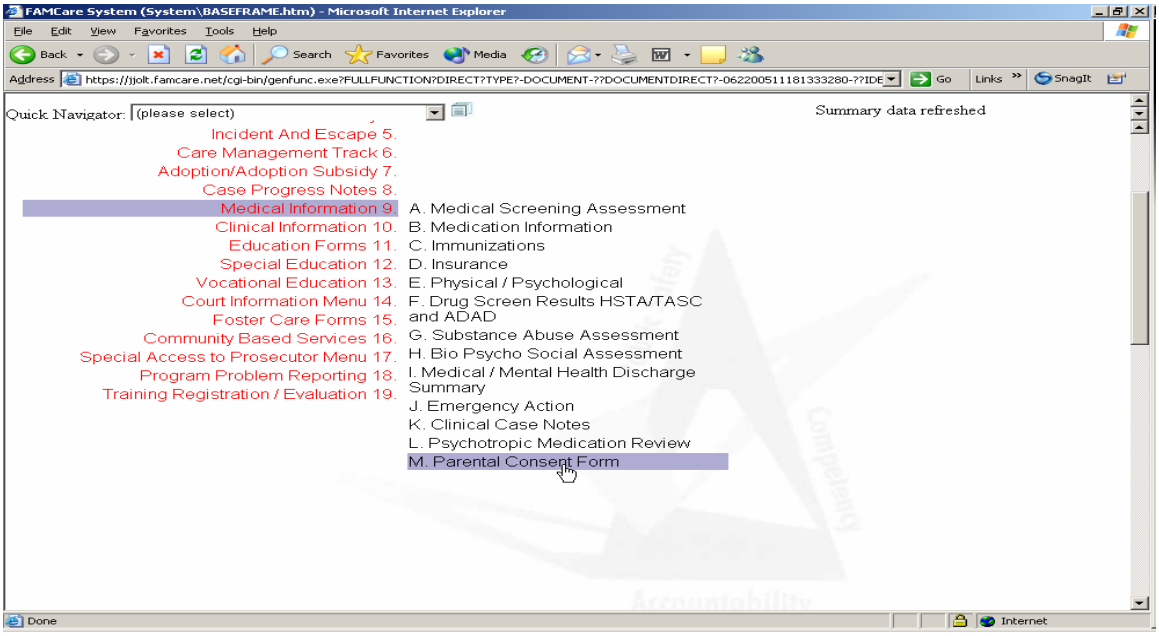
You will be able to access this form by clicking on 9L from the forms menu, once again will have the option to create new form or copy existing.

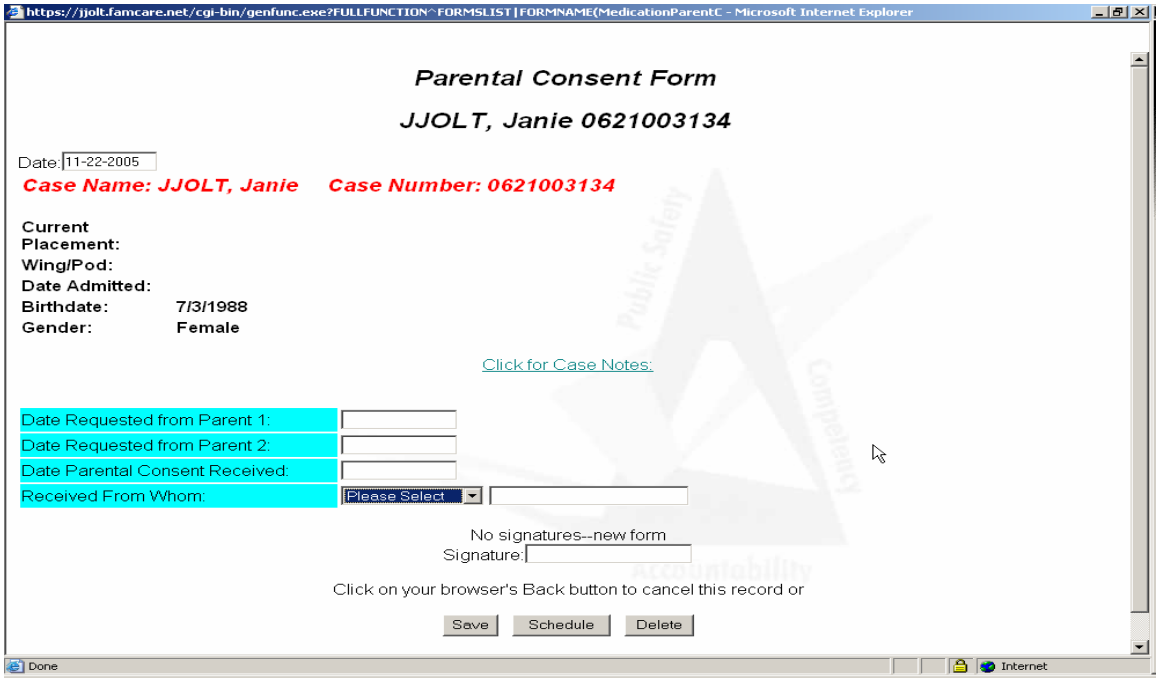




Parental Consent Form

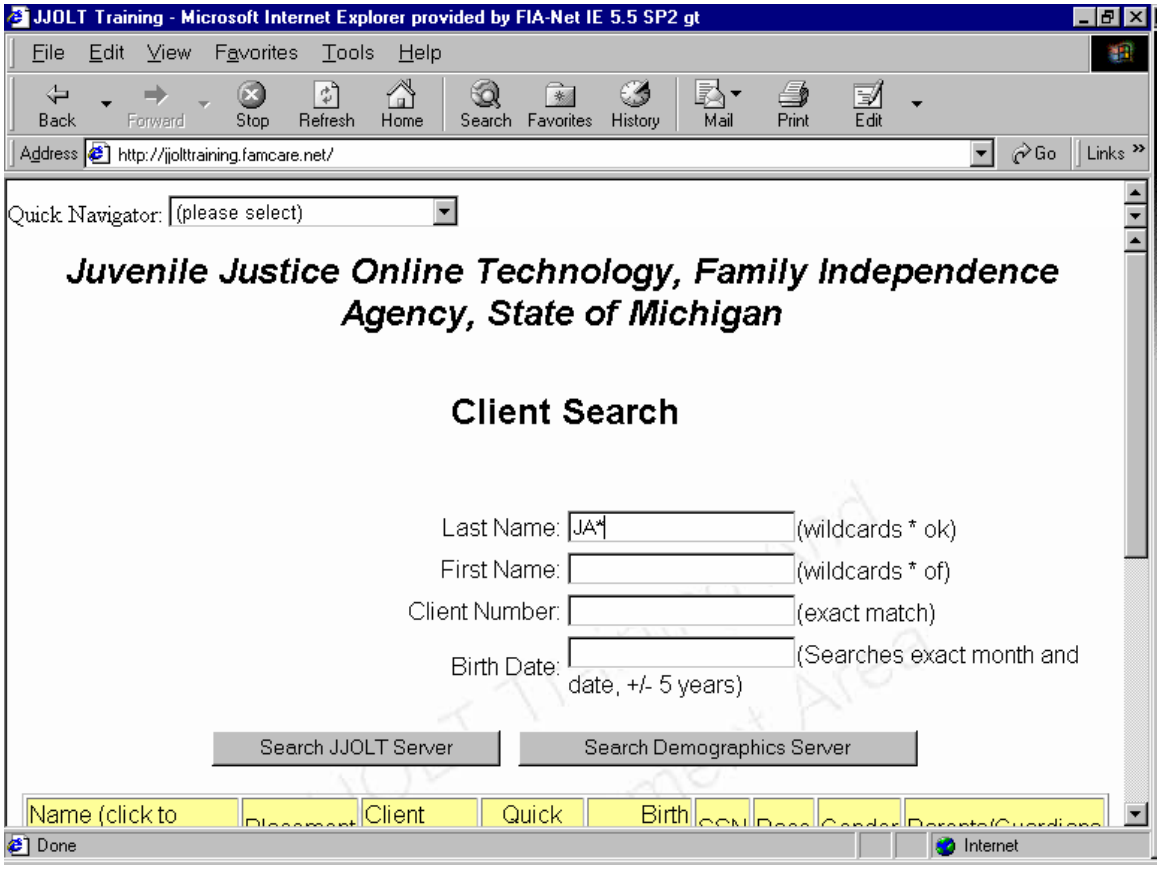
Select 9M from the forms menu to access the Parental Consent Form, you can either create new or copy existing.





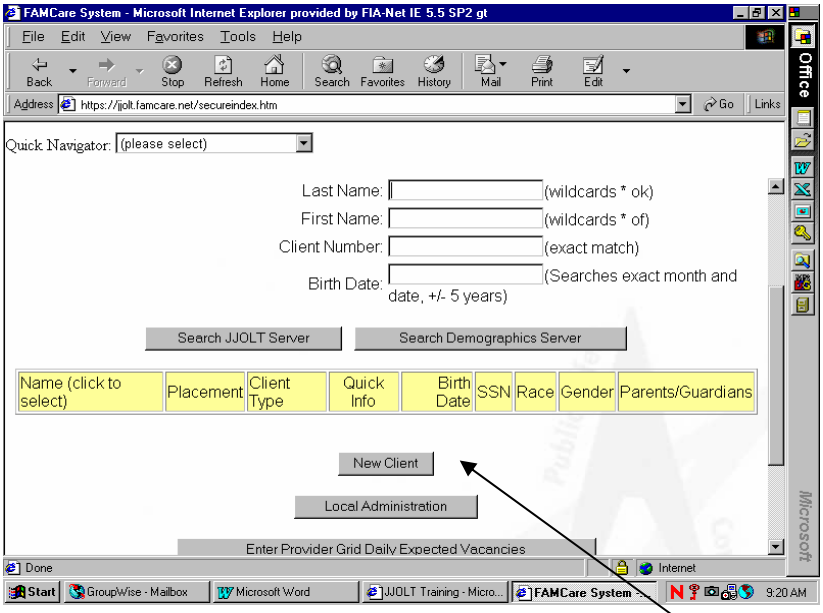
How to Search For and Create a Case Record

This will be the main screen you see when you sign on. This is a client specific program and you must search for your youth first before you add a new record. How to properly search for a youth is outlined below. This will help to prevent entry of duplicate case records.

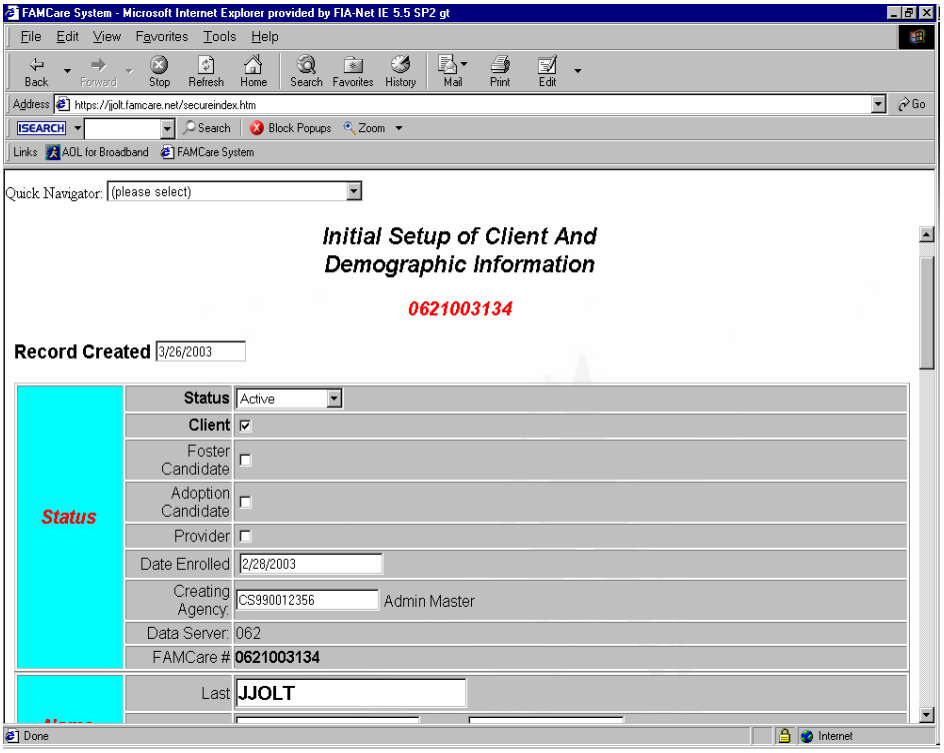


To generate a list of Clients using the "Quick Client Access" section, select a field (preferably Last Name) and type the first few characters that are known, then add an asterisk (*), which is a wild card (for example Ja*). First select the Search JJIS Server Button. If you still do not see the client that you are searching for, then select the Search Demographic Server Button, This will produce a list of Clients that have those characters in common. **Please search for, as few parameters as possible, do not type in full name**. This will insure that we are not creating duplicate records. This is very important when we have clients that have difficult Spelled names, or we have 2 kids with the same name, but different birth dates etc… When you get the screen that lists all the records, you can see which clients are "active," which are "enrolled" etc.

If you are still unable to find the client that you are searching for, please follow the steps listed below for creating a new case record



Click on the <u>New Client</u> button located at the bottom of the above screen. This will bring up a Client Demographic screen, please see below.



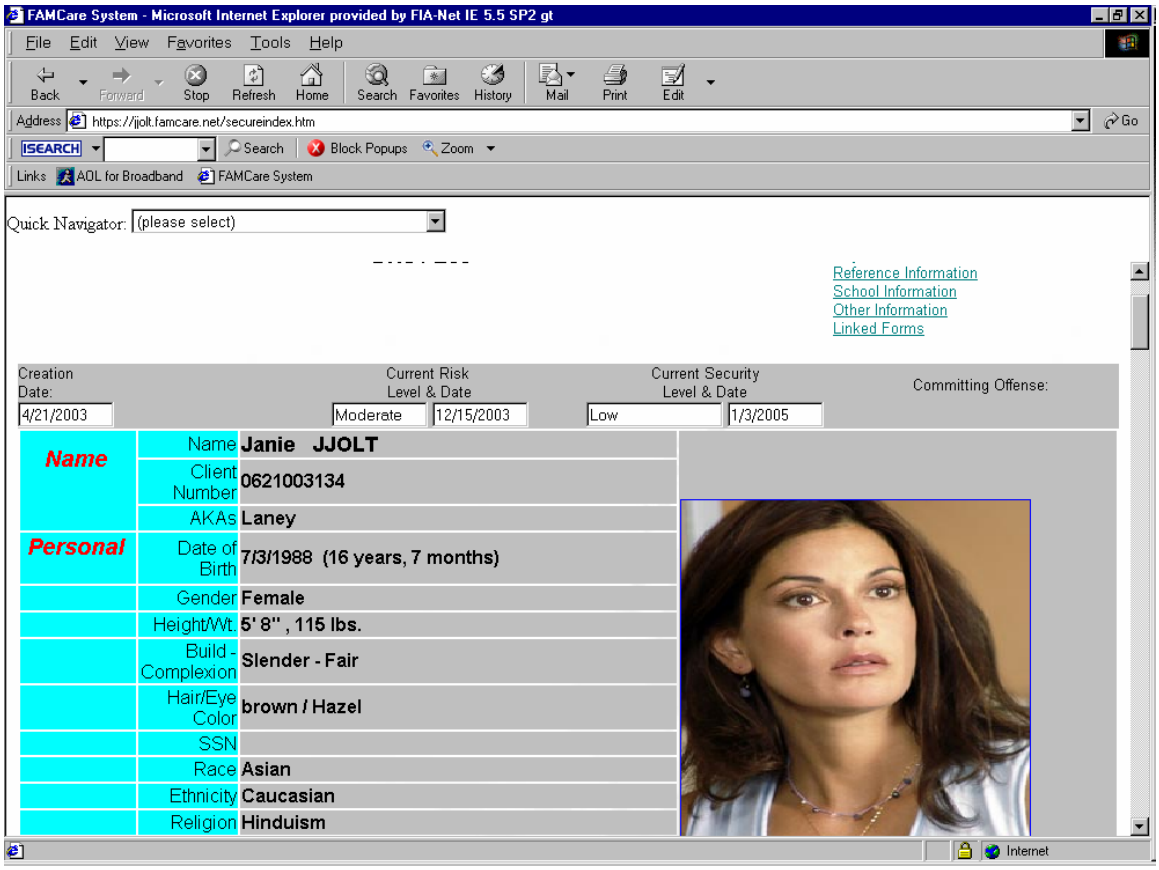
Creating a Client Record

To create a new record, you must place a check mark in the client box. **The required fields are the client's first and last name, gender, race and legal status.** The system will automatically generate a Client Number that is unique to this new client.

At the *Initial Setup of Client and Demographic Information* screen, also begin to add current address, phone numbers, identifying case numbers (FIA, JAIS, and SWSS), weight, height, hair and eye color, social security number, race, religion, ethnicity, language, and any additional information that you have. You may also add client and family history, if known.

After you have entered all of the above information, sign the form with your password, and save it. **Always read your full screen and make sure that you scroll down to the bottom of each screen. Often, you will get a message to "click here to refresh"; that is the way your master record is updated. This screen says please wait while the form loads.**

This brings up the "Intake Record" screen automatically. Since this form is so large, up to 10 seconds are needed for it to load. At this time, more data can be entered regarding client demographics, referral information, more of the client's legal, personal and family information, as well as history.

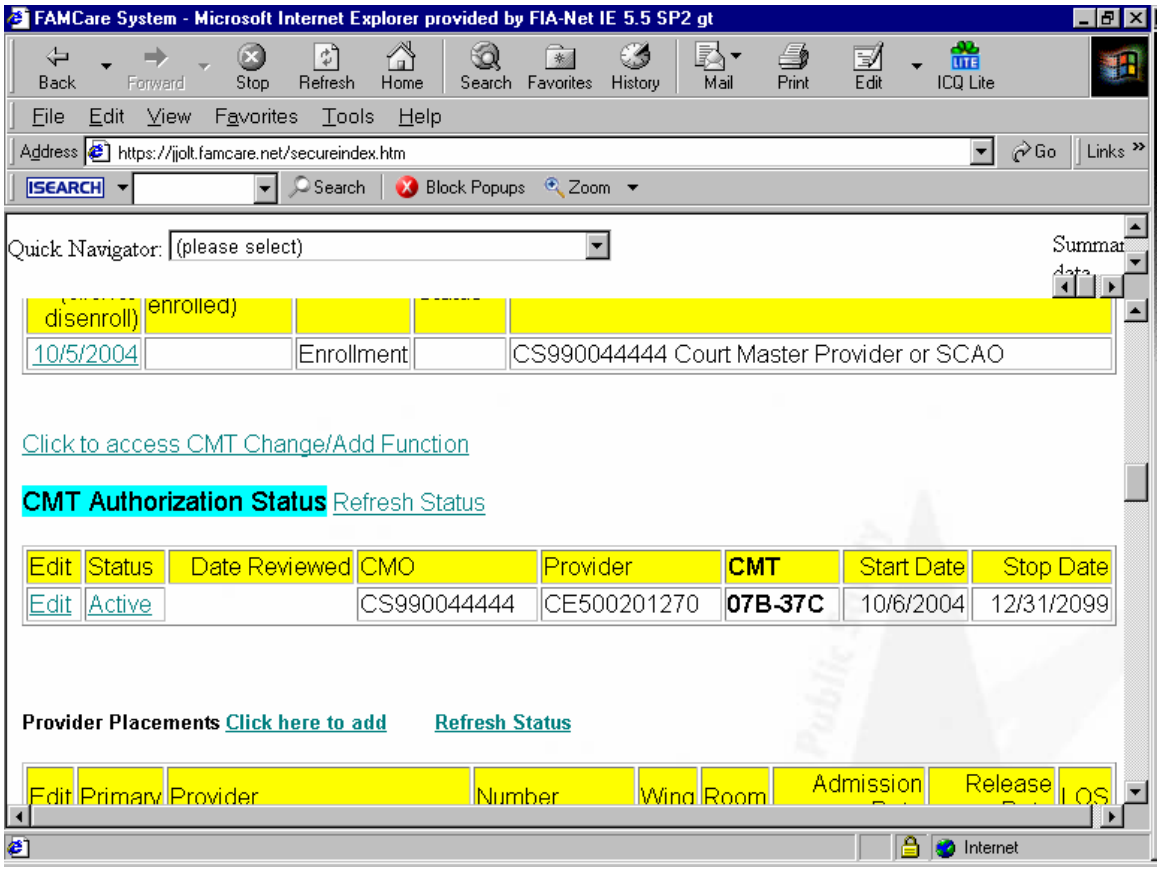


After creating a case record, it will automatically enroll your client to the top parent provider.

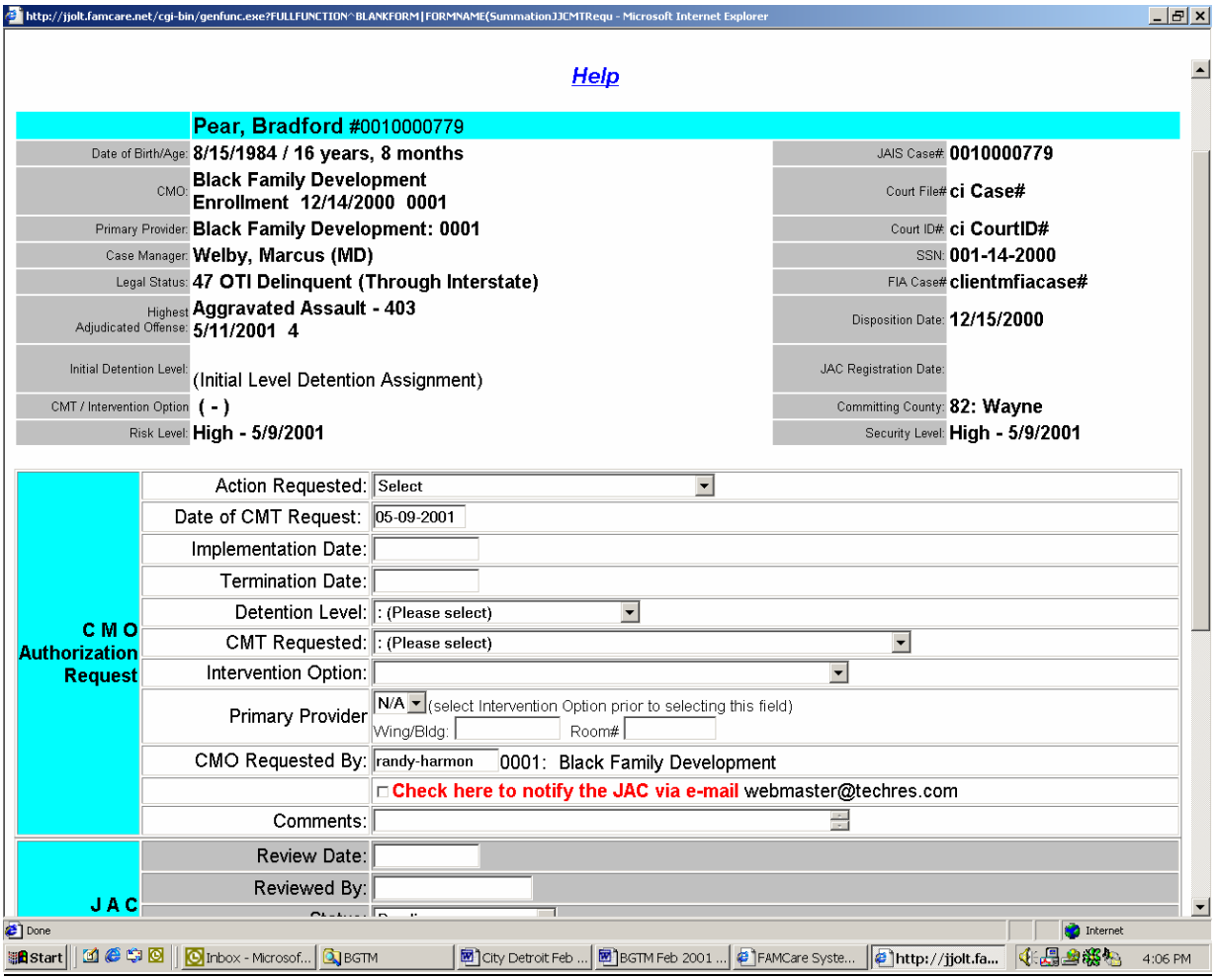
NOTE: Always make sure you also maximize the screen you are working on, this will ensure that you do not X out of your main screen, or close a form that you are working on without saving the information first.

SECOND: In the future you will add a Care Management Track for all youth other than those being referred to JJAU. Any Foster Care, SIL or Community Based program used must be tracked here. **The JJAU will currently do this section for those going to low, medium, or high secure facilities.** This is the main section relating to the activities required for a youth. The "Care Management Track Authorization Request" is an interactive form used by BJJ requesting any community-based program, a residential program, or by the JJAU for reviewing the record and placement of youth.

We will just briefly explain to you how the form works. From the "Intake Record" click to access CMT change/add Function "



When the CMT form appears, follow the instructions listed on the next page.

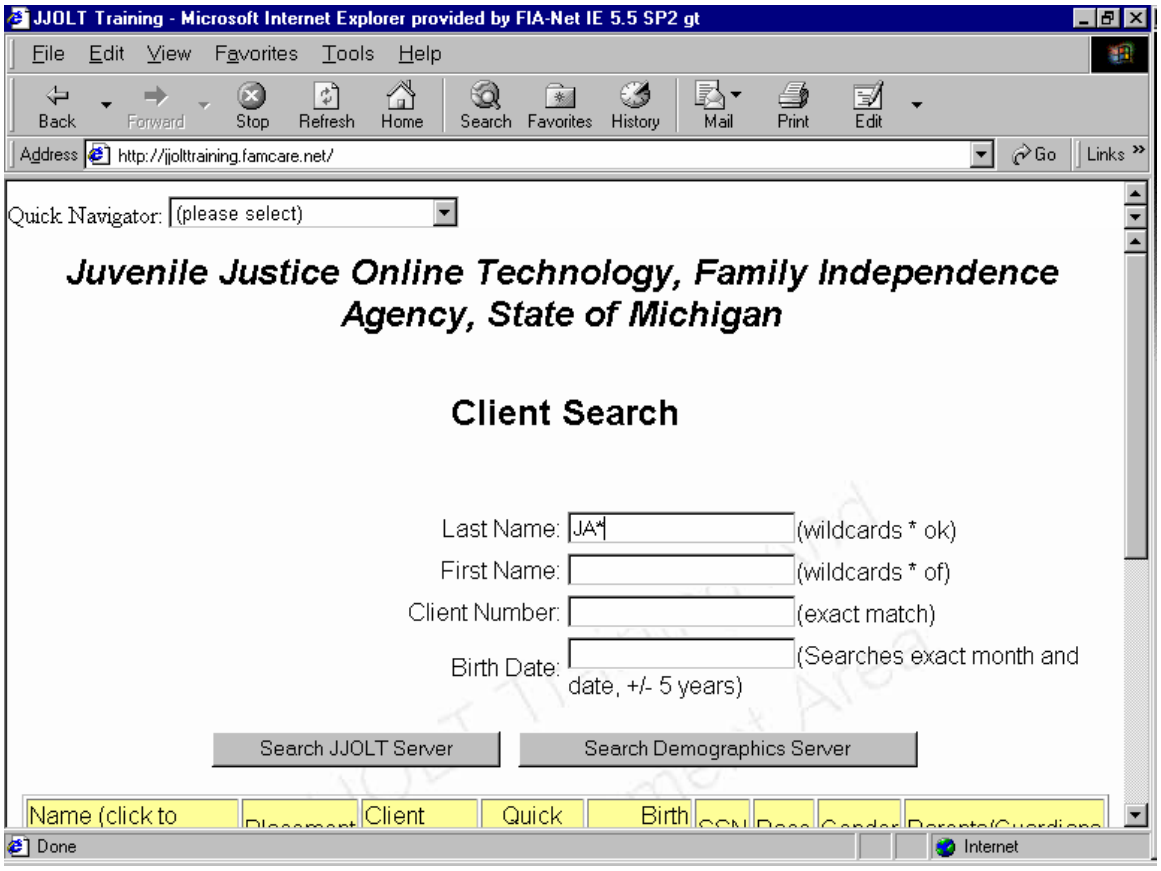


9. Action Requested = Change of CMT and/or Treatment Option or Initial Treatment or Detention CMT if this is a first time placement
10. Implementation Date = Date the Service is to begin (Admission Date)
11. Termination Date leave blank.
12. Detention level –Leave blank/ or 03A Secure Residential Detention
13. CMT Requested = choose the appropriate action i.e. Closed Medium Residential
14. Intervention Option = Choose the appropriate response i.e. Sex Offender Treatment
15. Only the Primary Providers who have that type of programming will be among the choices i.e. Adrian, Summit Center, etc.
16. Authorization status is Active And Approved
17. Sign, Save and Refresh

This will also now automatically update the Placement History when you 'refresh' that section. **As a provider it will be your responsibility to inform the JJAU when you admit a youth into your facility. They will adjust the CMT and you will then have access to the complete case record**

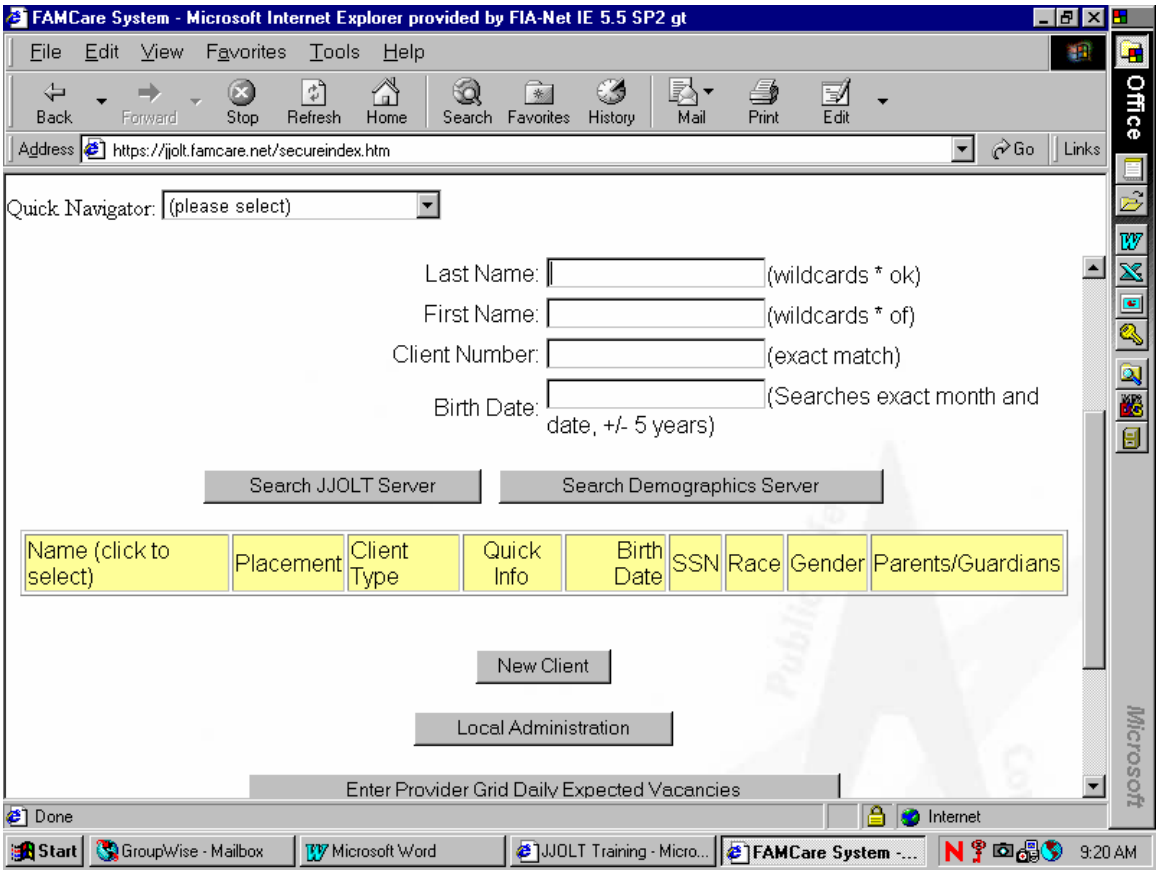
How to Search For and Create a Case Record for Detention

This will be the main screen you see when you sign on. This is a client specific program and you must search for your youth first before you add a new record. How to properly search for a youth is outlined below. This will help to prevent entry of duplicate case records.



To generate a list of Clients using the "Quick Client Access" section, select a field (preferably Last Name) and type the first few characters that are known, then add an asterisk (*), which is a wild card (for example Ja*). First select the Search JJIS Server Button. If you still do not see the client that you are searching for, then select the Search Demographic Server Button, This will produce a list of Clients that have those characters in common. **Please search for, as few parameters as possible, do not type in full name**. This will insure that we are not creating duplicate records. This is very important when we have clients that have difficult spelled names, or we have 2 kids with the same name, but different birth dates etc… When you get the screen that lists all the records, you can see which clients are "active," which are "enrolled" etc…

If you are still unable to find the client that you are searching for, please follow the steps listed below for creating a new case record



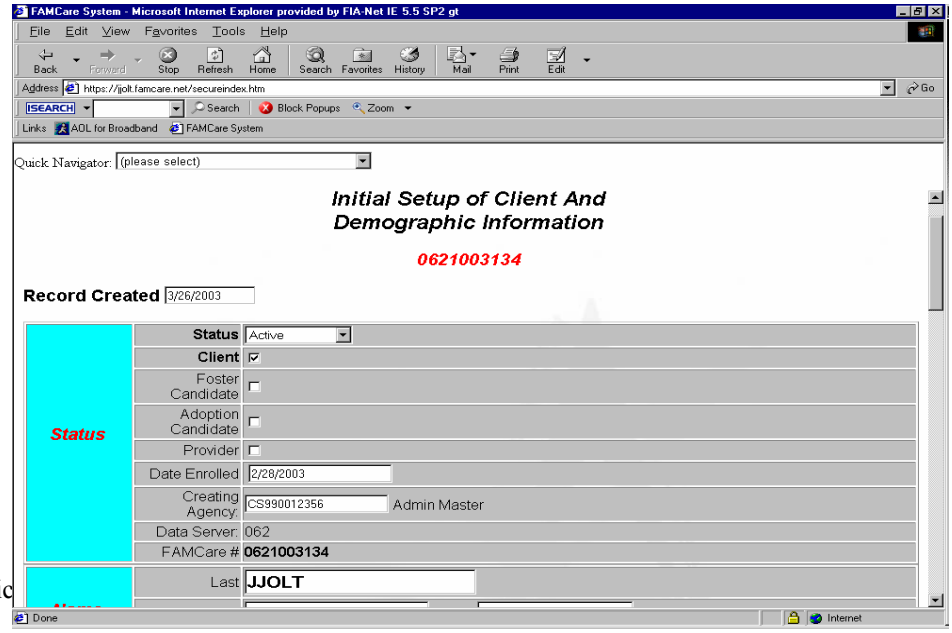
Click on the New Client button located at the bottom of the above screen. This will bring up a Client Demographic screen, please see below.

Creating a Client Record

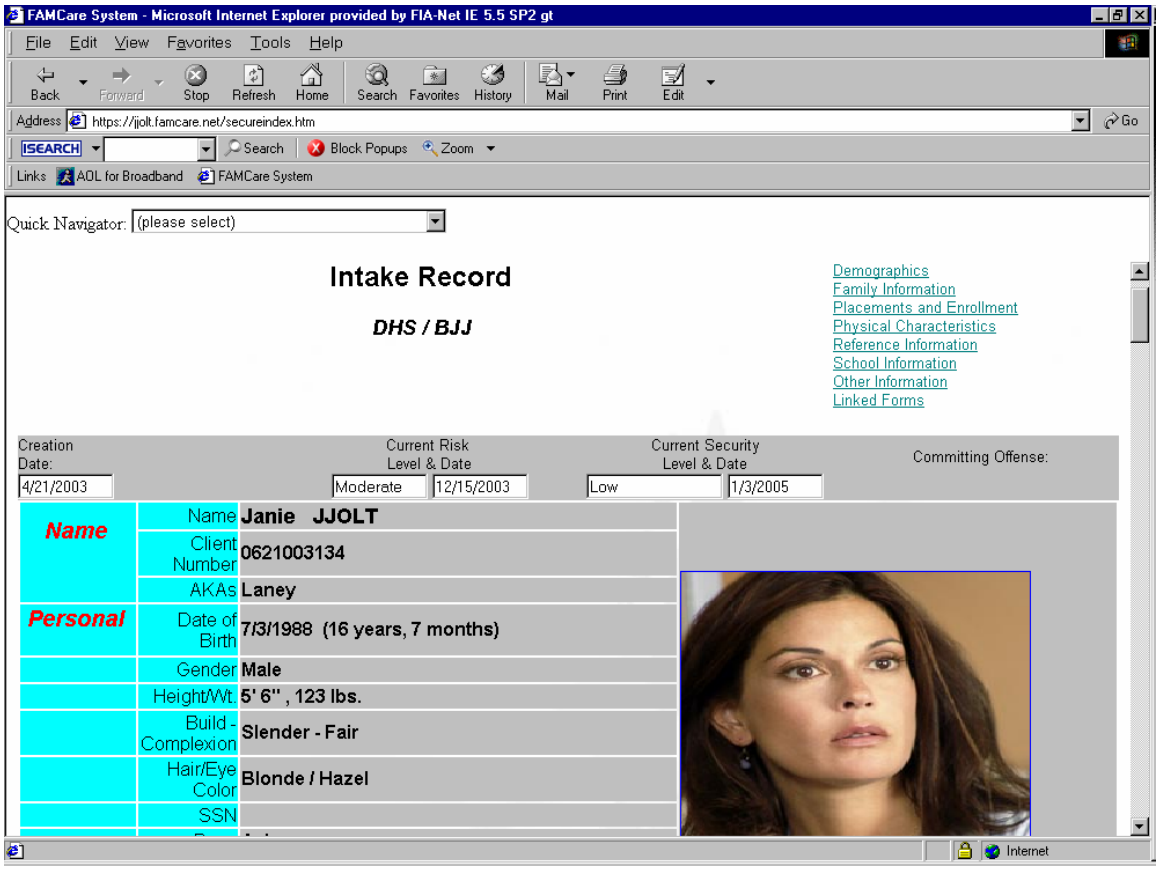
To create a new record, you must place a check mark in the client box. **The required fields are the client's first and last name, gender, race and legal status.** You can also add the social security number if known. The system will automatically generate a Client Number that is unique to this new client.

At the *Initial Setup of Client and Demographic Information* screen, also begin to add current address, phone numbers, identifying case numbers (FIA, JAIS, and SWSS), weight, height, hair and eye color, social security number, race, religion, ethnicity, language, and any additional information that you have. You may also add client and family history, if known.

After you have entered all of the above information, save your form. **Always read your full screen and make sure that you scroll down to the bottom of each screen. Often, you will get a message to "click here to refresh"; that is the way your master record is updated. This screen says please wait while the form loads.**



This brings up the “Intake Record” screen automatically. Since this form is so large, up to 10 seconds are needed for it to load. At this time, more data can be entered regarding client demographics, referral information, more of the client’s legal, personal and family information, as well as history.

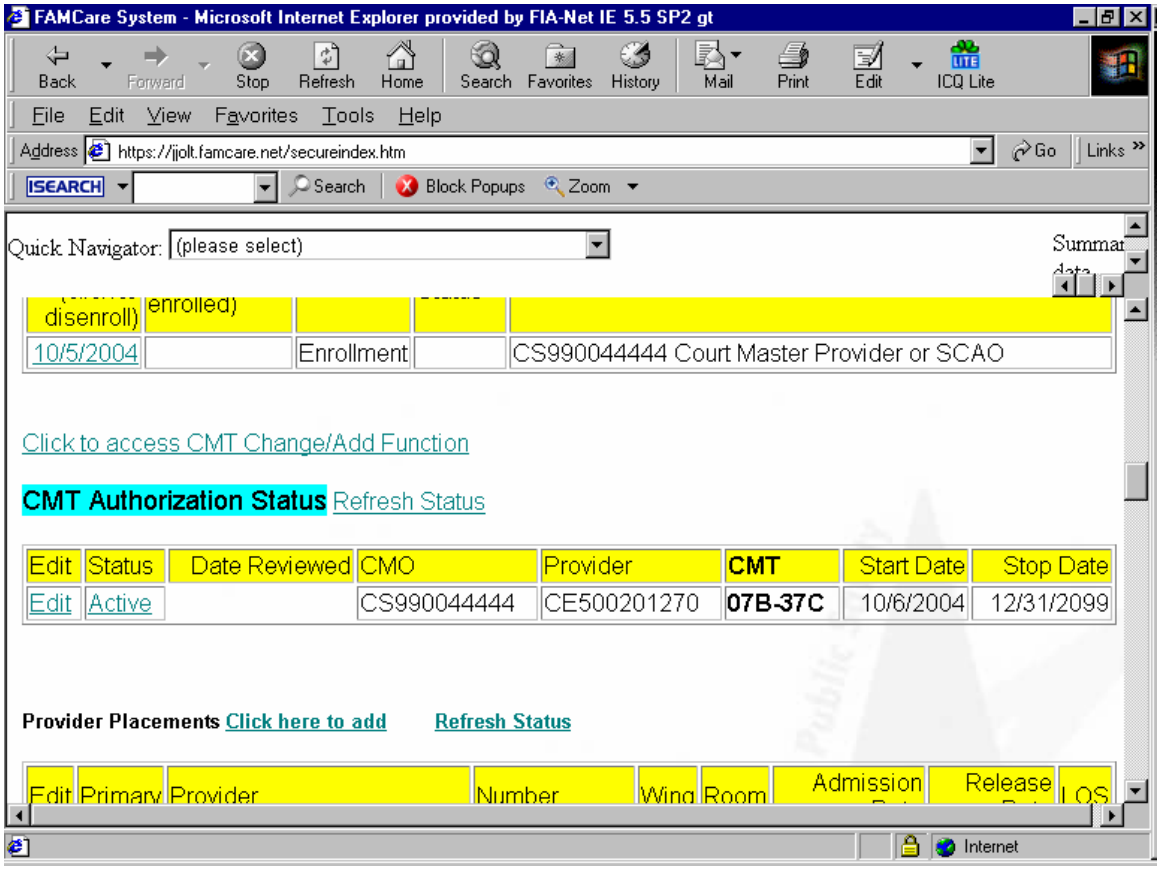


After creating a case record, it will automatically enroll your client to the top parent provider.

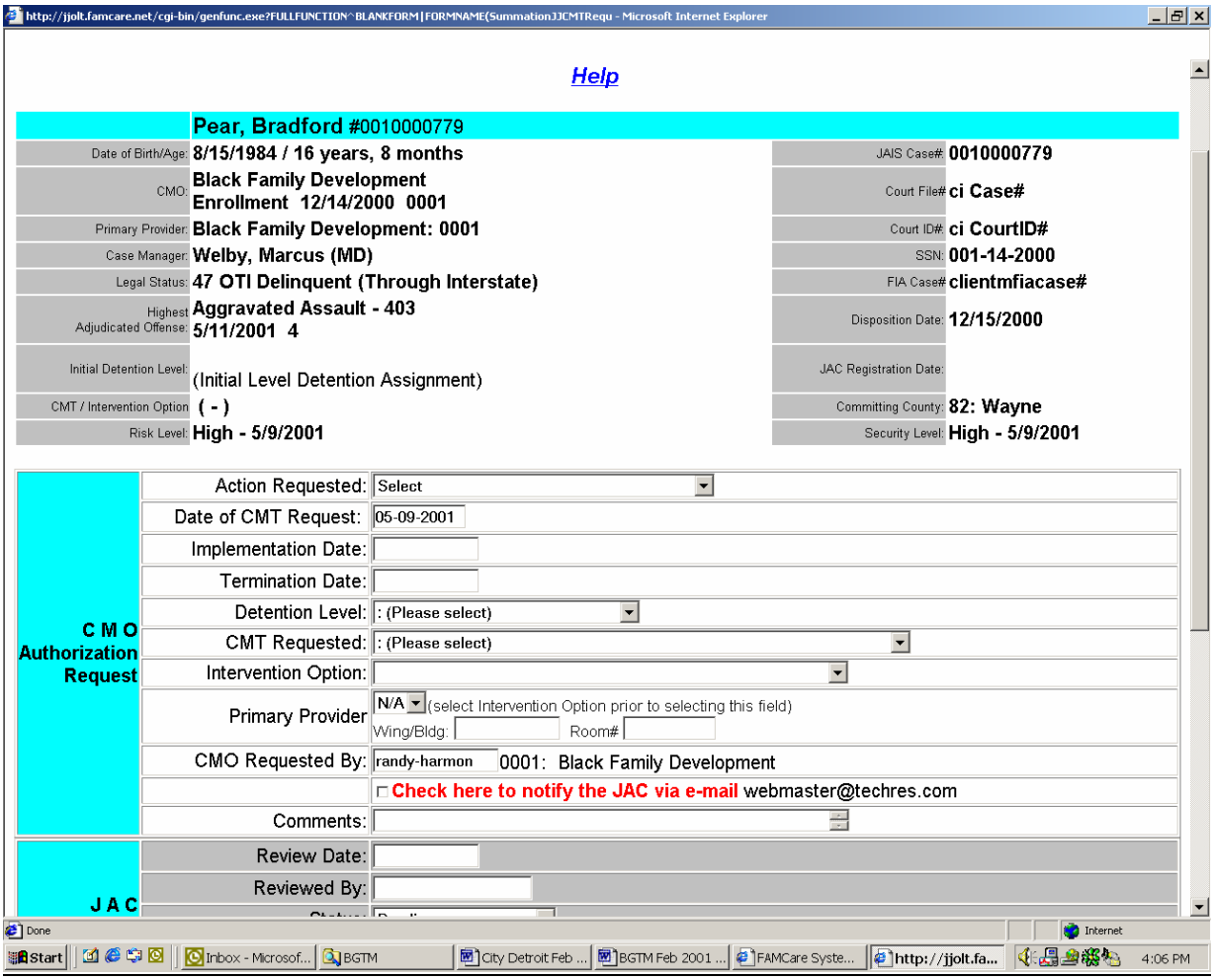
NOTE: Always make sure you also maximize the screen you are working on, this will ensure that you do not X out of your main screen, or close a form that you are working on without saving the information first.

SECOND: In the future you will add a Care Management Track for all youth other than those being referred to JJAU. Any Foster Care, SIL or Community Based program used must be tracked here. **The JJAU will currently do this section for those going to low, medium, or high secure facilities.** This is the main section relating to the activities required for a youth. The "Care Management Track Authorization Request" is an interactive form used by BJJ requesting any community-based program, a residential program, or by the JJAU for reviewing the record and placement of youth.

We will just briefly explain to you how the form works. From the "Intake Record" click to access CMT change/add Function "



When the CMT form appears, follow the instructions listed on the next page.



18. Action Requested = Initial Detention CMT if this is a first time placement or Subsequent Detention each time after
19. Implementation Date = Date the Service is to begin (Admission Date)
20. Termination Date = 12/31/2099
21. Detention level = Secure Residential Detention
22. CMT Requested = choose the appropriate action i.e. Residential High Security
23. Intervention Option = Choose the appropriate response i.e. Short Term Detention
24. Only the Primary Providers who have that type of programming will be among the choices i.e. Shawano, Washtenaw County Detention, GVRC (County), Monroe County Detention, etc.
25. Authorization status is Active And Approved
26. Sign, Save and Refresh

This will also now automatically update the Placement History when you 'refresh' that section

Department of Human Services

Juvenile Justice On-line Technology

JJIS

Training Manual

FOR RESIDENTIAL FACILITY STAFF

Department of Human Services

Client Management Session

4.0 Hours

Objectives:

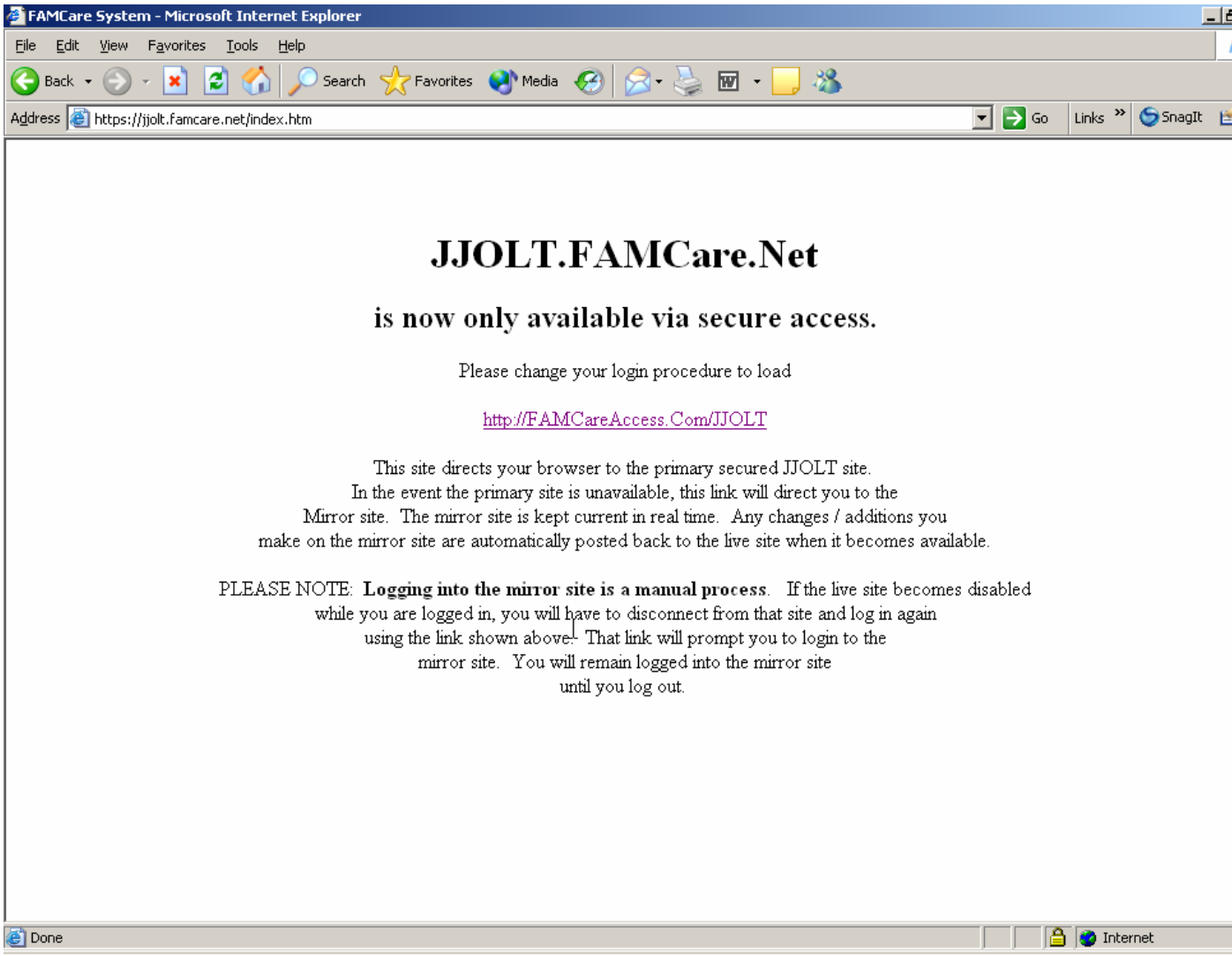
To ensure the operator can log on to JJIS and knows how to change passwords
To ensure the operator knows how to log off of JJIS
To give the operator an overview of the Client Menu
To ensure the operator knows some of the key forms in JJIS

Content Overview

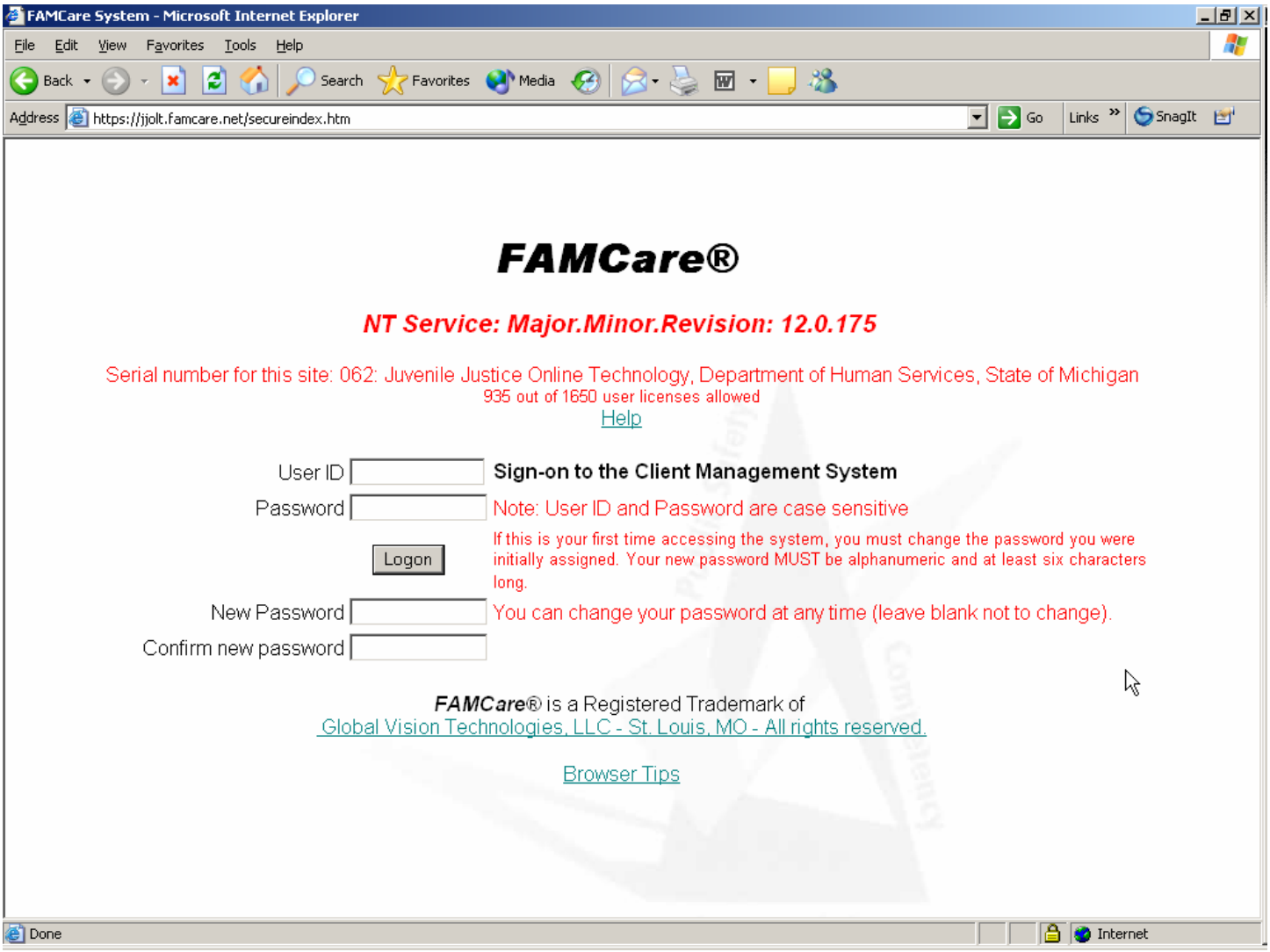
SESSION I
Pre-Logon Basics
Logon and Basic Navigation
Intake and Enrollment
SESSION II
Assessments and Treatment Plans
Incident and Escape
Education and Special Education
Q&A

Start/Programs/Internet Explorer E-mail address; DHS-ProjectJJOLT@michigan.gov
Address: HTTP://FAMCAREACCESS.COM/JJOLT
Help site: www.michigan.gov/dhs click on Juvenile Justice

The screen below is the sign-on screen for JJIS for DHS. Place your cursor on the line that states "Click here to sign on to Logon JJIS" and press the left button on the mouse or hit the "Enter" button on the keyboard.



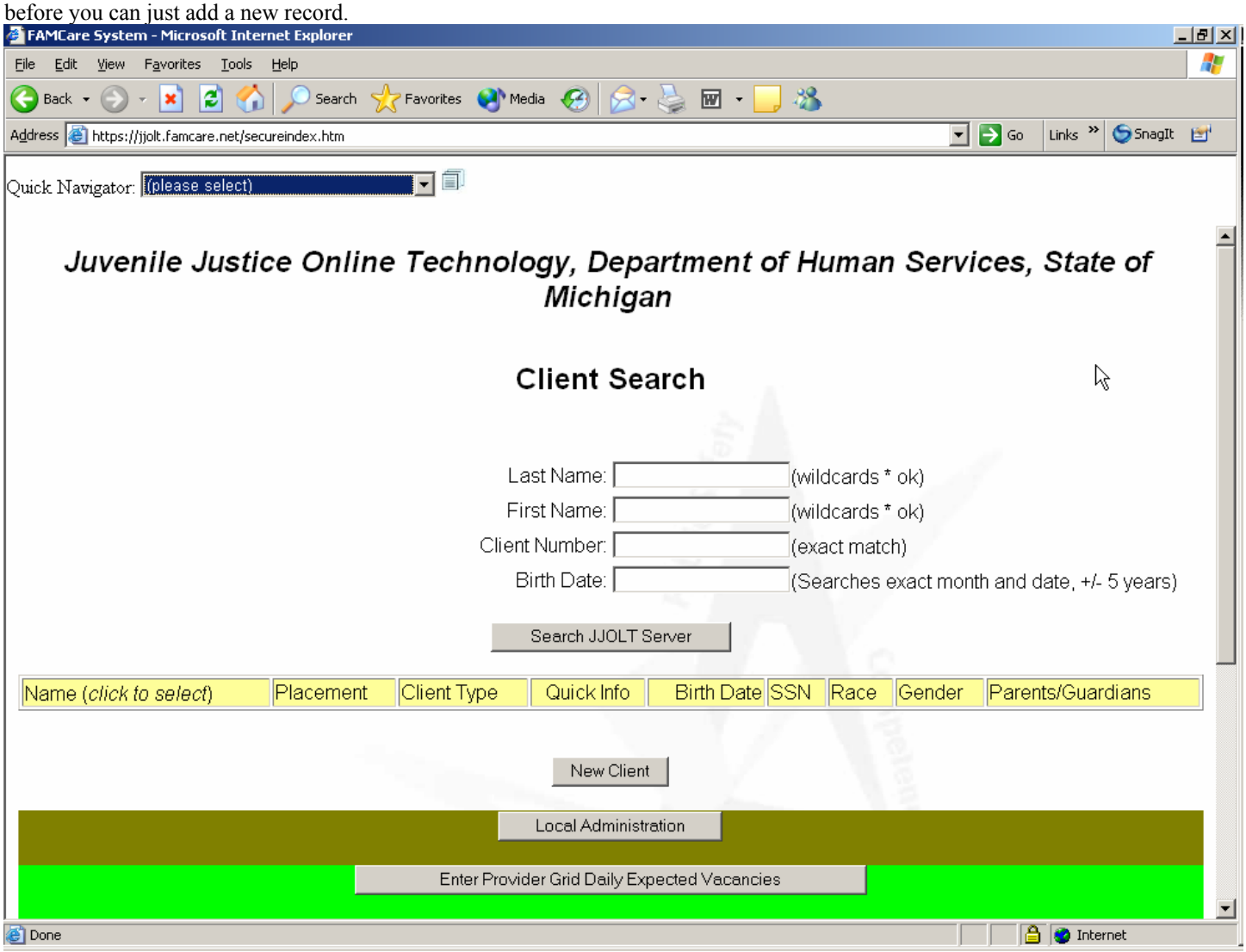
This brings up the sign-on screen, as well as a gray screen that contains the "Redistributable Code Agreement." Click on the "web address" on that screen, which will then leave the sign-on screen, as shown below.



From this sign on screen, enter your user name (First-Last) and initial password you are given (123456), **then go down to "New Password" and create your new password**. Confirm it, then click on the "Logon" button. This will produce the main master session menu (next page). **DO NOT CLICK ON LOGON UNTIL YOU CREATE YOUR NEW PASSWORD. YOU MUST CREATE YOUR OWN UNIQUE PASSWORD THE FIRST TIME YOU SIGN IN. ALPHANUMERIC, AT LEAST 2 LETTERS OR NUMBERS!**

You will then get a message that your password has been successfully saved. Click to continue. You will get a message every 2 months to update/change your password.

This will be the main screen you see when you sign on. This is a client specific program and you must search for your youth first before you can just add a new record.

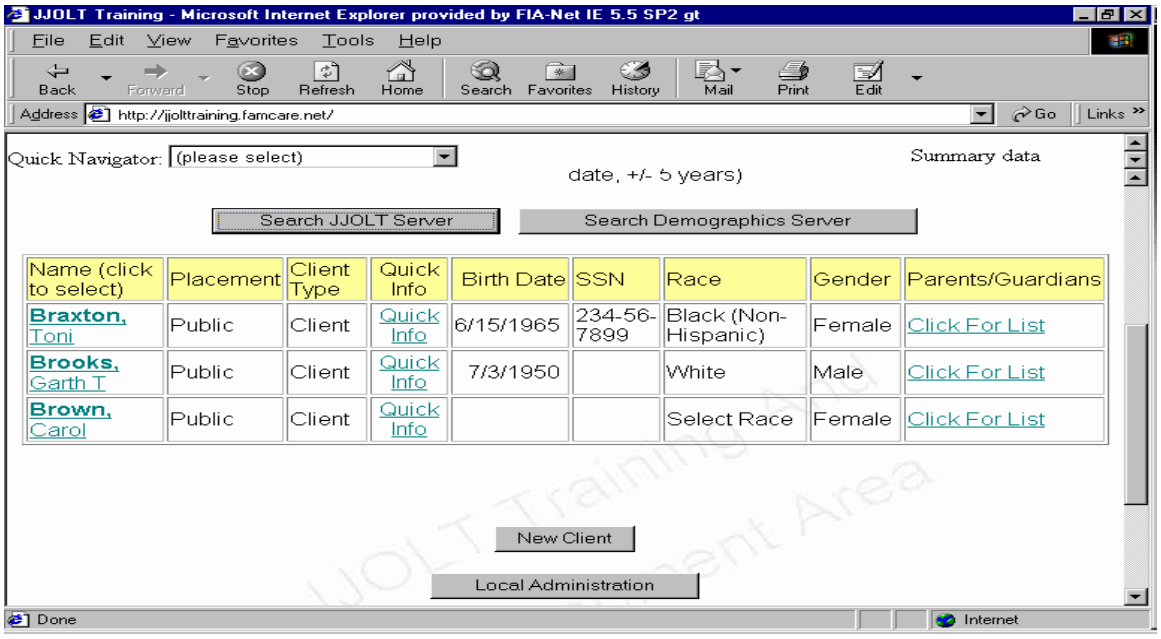


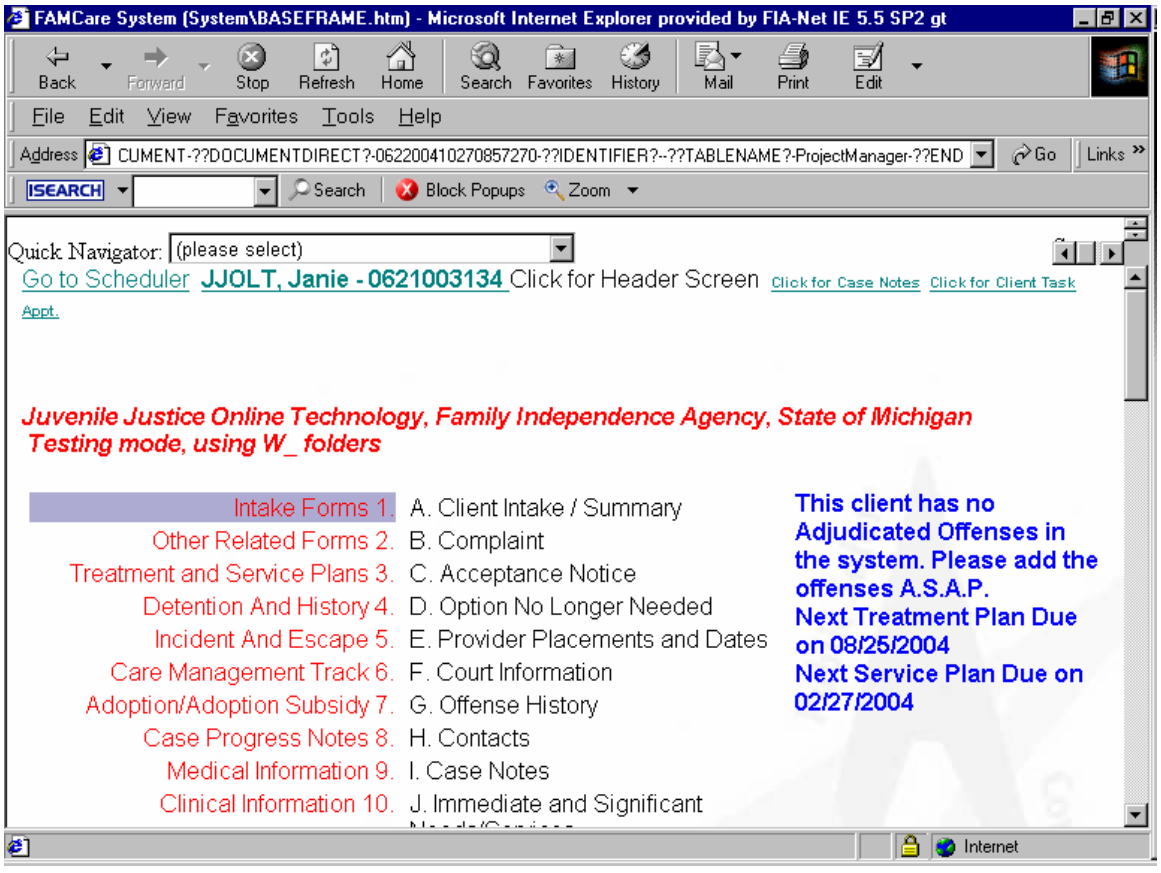
To generate a list of Clients using the "Quick Client Access" section, select a field (preferably Last Name) and type the first few characters that are known, then add an asterisk (*), which is a wild card (for example Ja*). First select the Search JJIS Server Button. This will produce a list of Clients that have those characters in common. **Please search for, as few parameters as possible,(Please do not type in full name)**. This will insure that we are not creating duplicate records. This is very important when we have clients that have difficult spelled names, or we have 2 kids with the same name, but different birth dates etc… When you get the screen that lists all the records, you can see which clients are "active," which are "enrolled" etc…

If you do not see the client on the list, this means that you need to do another search using fewer parameters (again search only for a few letters in last name only). You should never be assigned a youth that is not already in the system, if you can still not find a youth, contact the JJIS Help Desk.

To access a specific Client, click on the Client's Name. Check to make sure this is the same youth you are looking for by viewing the Date of Birth/SSN if available. If it is correct, this will bring up this youth's record and you can begin to add updated information.

Clicking the "Client's Name" brings up this "Forms Menu".





Client Intake Summary (Menu Option 1-A)

Forms Menu

The top of the page contains the Client's system-assigned number as well as name. The forms are organized into categories. To open a form, select the category on the left column and then click on it, which generates another list of forms. As each form is built, it automatically populates other required forms for this same Client.

There are detailed "Help" screens that walk a user through the Client record building process. Select the proper "Go" button for the necessary help.

Quick Navigator

At the top of the main screen you will also see a "Quick Navigator" bar. Clicking on the field produces a small dropdown menu of the different areas for which the user has been granted access. This allows to more efficient movement around the system to avoid backing out of various screens to reach the main menu. You can return to the "Client Menu" screen to find another client, or you can go to the Main Forms menu for the client you are currently working on, or you can Log Off the system. **If you see this Quick Navigator you always know you are in the main screen, and this is how you move around the system. Do not use the X button at the top right hand side of your screen to close out, This will take you out of the system, and you must start all over, and you may lose information you were working on. The same is true for the 'Back" button, you may not save the information you were working on. Get in the habit of using the Navigator.**

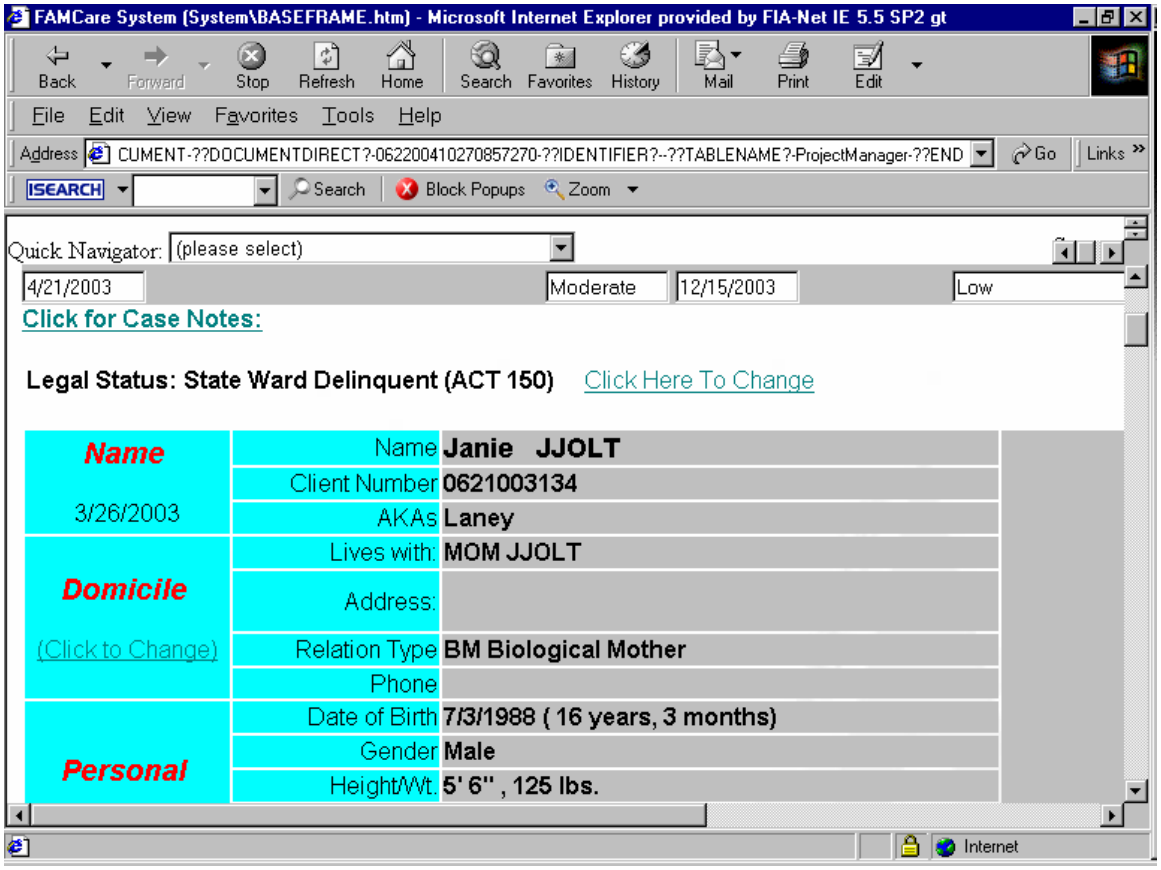
If you accidentally X out of the system, you will have to log back in to JJIS, sign in again, restate your password, and search for the youth record that you were working on.

As you are working in the system, often you will be adding information to "Forms within Forms". Look for your Quick Navigator, if you do not see it you can use the X button to close out of that particular form.

Any time you add information to a form, you must SAVE, and then follow your screen buttons to refresh, If you are just viewing a form you can X out of it if you have not added any information.

Building a Client Record

The "Client Intake / Summary," form 1A continues for many pages. It is the critical form for entry into the system.



Note at the top of the form the Client's current Security and Risk Levels. These are pre-populated from risk assessments. There is also a box with the "Client's Highest Adjudicated Offense," which is pre-populated from "Offense History."

The top of the "Intake Record" form also shows links to various sections of the form, which are just shortcuts vs. scrolling down the page. The "Intake Record" also contains links to several other screens that supplement the basic Intake form.

Other Links on the "Intake Record"

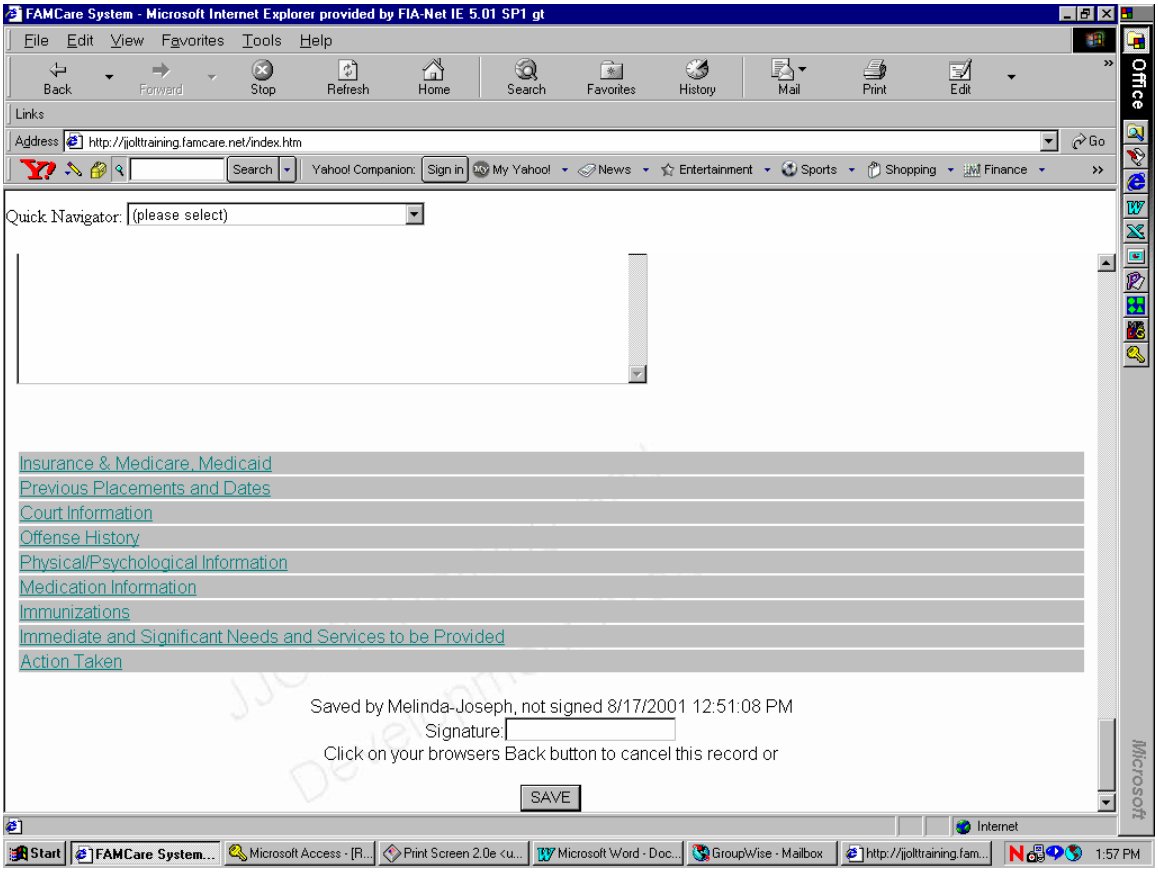
Other links are described below, which allow for more complete data entry during the Intake process. These screens can also be accessed later through the "Forms Menu."
Regarding all the items in this section, once input is complete, click on "Save" to save the input or the "Back" button on the browser menu to cancel the input. An option exists on the "Save Confirmation" screen to also print out a hard copy of the record. Completion of this task and hitting the appropriate button on the "Save Confirmation" screen will take the user back to the "Forms Menu" for that Client.

Parent/Guardian Information or Contacts

The "Parent/Guardian Information" link provides significant information regarding all contacts involved with the Client and the treatment plan. Each Contact record will contain data regarding that person's relationship with the Client, privileges, role in treatment, demographics, insurance (if applicable) and possible restrictions regarding visitation.
To begin

6. "click here to add"
7. This will bring up a Search Screen. Again, you must search for this contact, as they may already be in the system as a contact for another youth. Type in the contacts' last name (also using a wildcard Ja*). If they are in the system you can just click on their name and add the new information. If not you must click on the "Add a new contact to the master record"
8. Add all know contact information (name, DOB, Address, phone, etc.)Sign and save this form.
9. You then must add Relationship details. It will only show up on the intake record as a Parent or Guardian if you have checked those boxes. Also, if you check Main Domicile, you will change the youth's main record to the parents' address. Also, it will only show up as Contact Restrictions if you check the appropriate box.
10. Sign the form, Save it and then you will get the confirmation screen. Scroll down until you see the Click here to refresh summary, and you will then return to your main Intake record, and the information added should be there.

Continue to Scroll through the Intake Record adding all information available. Case manager is the JJS worker. Committing County and Referring County, Committing Offense, Religion etc.
At the bottom of the screen you will see links for Offense History, Medical /Psychological Information, medication Information etc. Add all information that you have available. If you do not have it, that is OK, only add what you know.



Previous Placements and Dates
This part of the form is automatically updated when the Intake Unit admits a youth to a program; you should not have to add any information to this section. This will also pre-fill in the appropriate areas of your Treatment Plans.

Offense History
This form is self-descriptive, allowing for input of the Client's offense history. For each Offense, and Adjudication date and status must be filled in.

Physical/Psychological Information
This form is self-descriptive, allowing for input of the Client's current physician and psychiatrist, the date of the last physical exam, and notes. A link is also provided to the Medications and Immunizations forms.
Medication
The "Medication" form is used to document all medications prescribed for the client, including prescription number, pharmacy name, referring physician, dosage and any special instructions. Each type of medication requires a separate record, which can also be edited. This section is required for all agencies to keep updated. Any time a youth has a medication change, the Group Leader, Medical staff, or whoever is assigned must go in and complete this information. If a client refuses to take their medication, this can be addressed in an Incident Report, which will link itself to the Medical Section in JJIS

Immunizations
The "Immunizations" form is used to document any immunizations that the Client has received and also to input those that are necessary but not yet received (or expired). You may also be able to scan in an immunization record so it is always available.

Immediate and Significant Needs and Services to be Provided
This form consists of text boxes for special notes regarding the physical needs of the Client and/or emotional needs of the Client and parent. This is excellent for intake staff and would be helpful if staff kept this up to date.

Saving Information
At the end of your Intake Summary, one last time you must sign and save your complete form. The computer does not know that you are actively working on a record unless you are hitting any save button at least hourly. If you have not done this, you may get kicked out of the system and not even know it, thus none of your information will be recorded. **Make sure you are saving regularly!**

CONTACTS/CASENOTES
Some people prefer to create Case Notes/Contacts as they occur individually, and some prefer to jot them down on paper then add them all at once while writing a Treatment or Service Plan. Either way, the data entry is the same.
Click on the ***Add Case notes*** anywhere from within 1A, from 1I, from 8B, or while in a treatment plan.

1. You will type in the date the case note occurred, time is optional.
2. Select the type of contact from the drop down box.
3. Select the contact person (you can select multiple people by hitting your control button and your mouse at the same time to select or deselect multiple people). If your contact is not listed, you will click on ***Add Contact***, and refer back to Parent Guardian info section to create a contact and relationship. Also you can check whether the JJS was a part of this case note by checking that box.
4. Remarks is a brief description of the case note that will appear on your Plans, Description is a more in depth text of what occurred. Someone would have to open this case note up directly to get this description.
5. Select where you want this case note to populate i.e. Treatment Plan, Service Plan (for JJS workers only) Medical etc… Most of you will always select Treatment Plans.
6. There is a Private box, these are notes that only you will have access to. No one else will even see that they were created. This is generally used for the Clinical Psychiatric staff, but if you use this selection these will not show up on Treatment Plans.
7. Your choice then will be to either **Quick Save**, which will then allow you to add another case note and so on until you have added, all that you wish, or **Save/Close** which will save that case note and return you to the main form you were working on. (You can also cancel the case note and return to your form etc…) The schedule button is not a functional part of the case note section at this time so you do not need to worry about this at this time.

Your case notes that occur within your Treatment or Service Plan reporting periods will automatically show up no matter where they were created from.

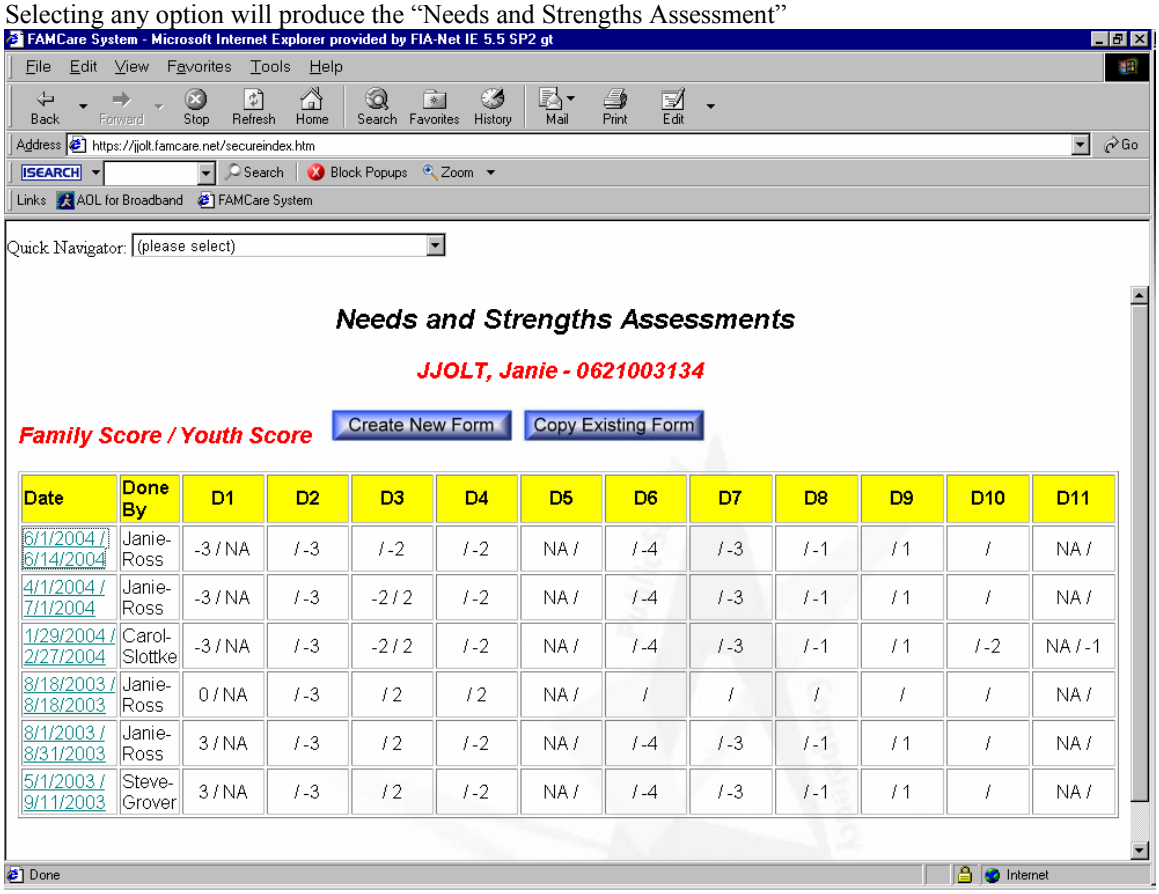
Session II – Assessments and Treatment Plans

Once the "Intake Record" has been completed, the Client's assessments are entered next. The Treatment and Service Plans "Forms Menu"(3 A<B<C<D<E<F<G<H) contains the assessment forms that are available for various purposes.

Client Menu #3-G. **Strengths/Needs Assessments**

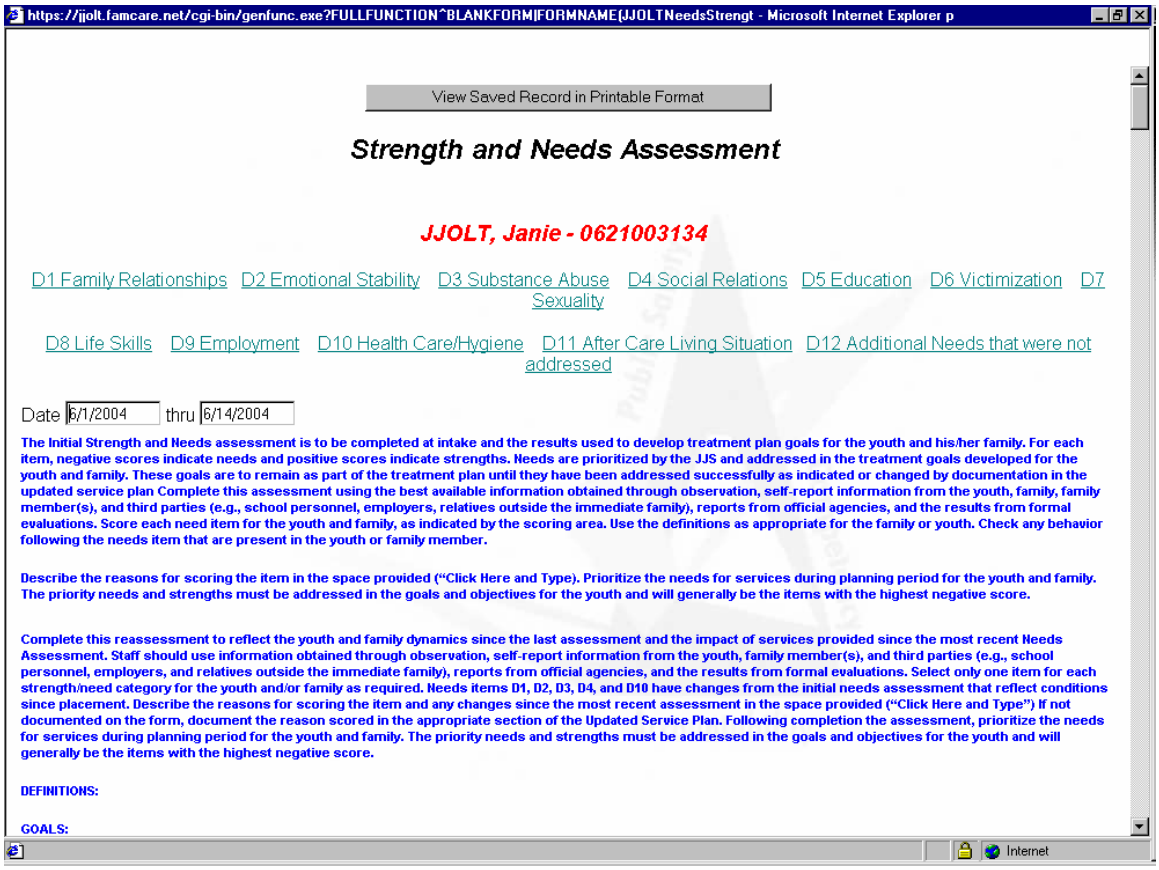
One of the key forms in this section is the "Strengths/Needs Assessment" form, which is used to develop the Initial and Updated Service Plans. This screen will also be revisited to update the Residential Treatment plans or develop a Release plan. Click on this line item to select it from the menu to create a stand-alone document. This will take you to the next screen to select a new form or to select a form with the last-inputted forms data pre-populating it, or edit an existing form. You can also reach this form by selecting 3C and creating your Initial or Updated Treatment Plans.

Selecting any option will produce the "Needs and Strengths Assessment"



Date	Done By	D1	D2	D3	D4	D5	D6	D7	D8	D9	D10	D11
6/1/2004 / 6/14/2004	Janie-Ross	-3 / NA	/ -3	/ -2	/ -2	NA /	/ -4	/ -3	/ -1	/ 1	/	NA /
4/1/2004 / 7/1/2004	Janie-Ross	-3 / NA	/ -3	-2 / 2	/ -2	NA /	/ -4	/ -3	/ -1	/ 1	/	NA /
1/29/2004 / 2/27/2004	Carol-Slottke	-3 / NA	/ -3	-2 / 2	/ -2	NA /	/ -4	/ -3	/ -1	/ 1	/ -2	NA / -1
8/18/2003 / 8/18/2003	Janie-Ross	0 / NA	/ -3	/ 2	/ 2	NA /	/	/	/	/	/	NA /
8/1/2003 / 8/31/2003	Janie-Ross	3 / NA	/ -3	/ 2	/ -2	NA /	/ -4	/ -3	/ -1	/ 1	/	NA /
5/1/2003 / 9/11/2003	Steve-Grover	3 / NA	/ -3	/ 2	/ -2	NA /	/ -4	/ -3	/ -1	/ 1	/	NA /

Form, as shown on the next page. It looks just like our current Word document.



Once the record has been saved, the "Save Confirmation" screen appears. This has the same functionality as the "Save Confirmation" screen for the "Intake Record" – a printout can be produced or the user can go directly back to the "Strengths/Needs Assessment" screen to make further modifications to the Client's record.

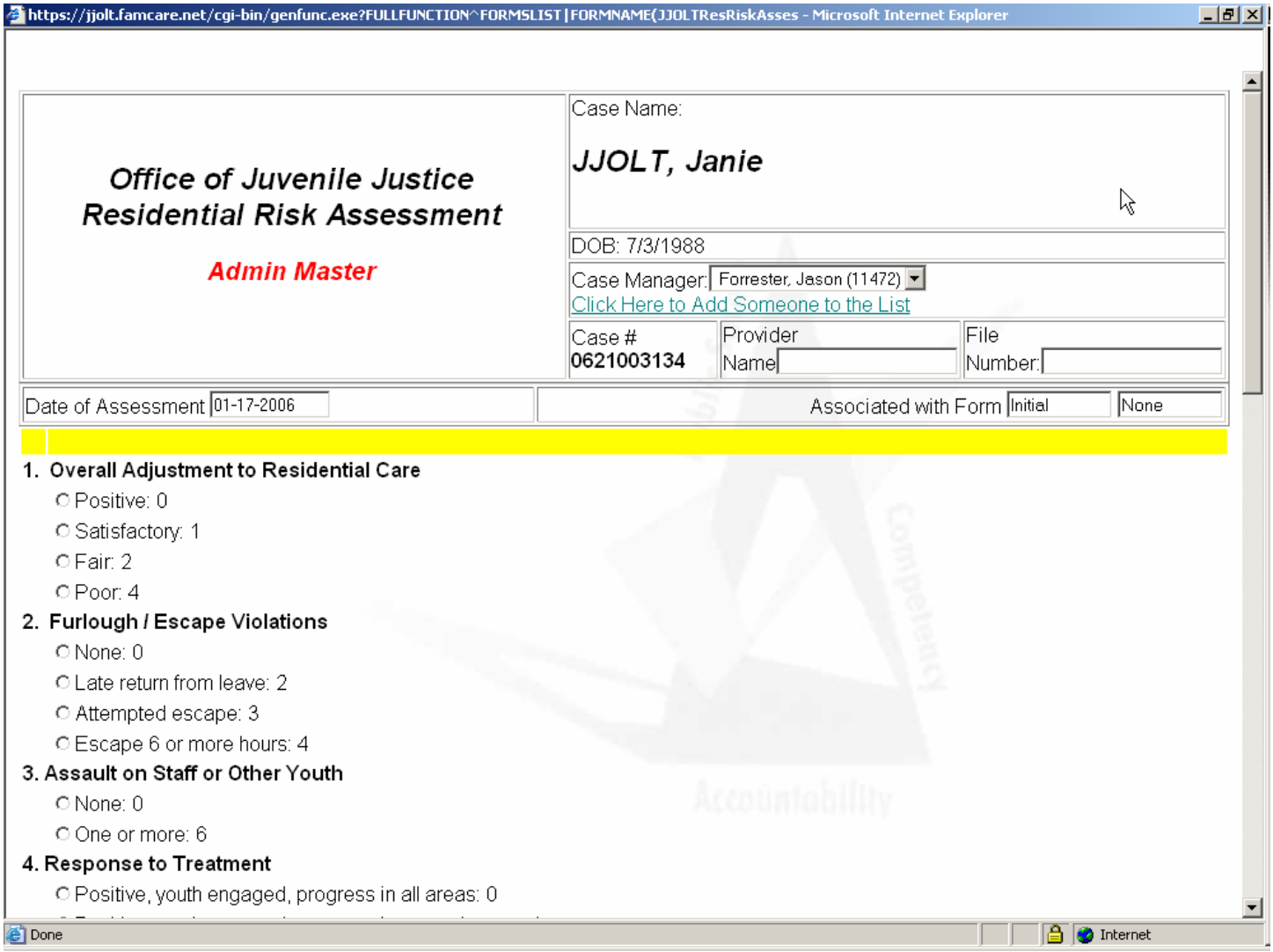
The easiest way to input your goal information is to:

1. Place your cursor behind the word 'Goals'. Add your Goal statement then hit enter. You will start your next line.
2. Place you cursor behind the words "A. Time Frames" and type in your time frame (i.e. 6 to 12 months) then hit enter.
3. Place your cursor behind the words "B. Objectives" and type in your objectives and hit enter. Do this until you have completed "D. Individuals Responsible" and Your Goals along with A<B<C<D should all be in a neat line.

You can also cut and paste form a Word document if you prefer. The document does have Spell Check now and each section that has a text box should have the spell check in the margin area. It does not spell check your entire document at once; however, you must check each individual text section.

Juvenile Classification and Assignment

The "Juvenile Classification and Assignment" form is created by the JJS and utilized by JJAU and Treatment Programs to determine a Client's initial risk and security classification. Again, this form looks just like our current word document.
NOTE: As with the other risk forms in this section, the risk scores will be automatically calculated each time the information is input and updated. However, in this case, this is a one time only form. The Highest Adjudicated Offense will then automatically pre-fill the security level, and then you can scroll down and fill in an override if necessary.



Make sure you click on the box that tells you to "Update Master". This will then update your face sheet.

Initial and Updated Service Plans (view access only)

Once the Client has been entered into the system and has been assessed, an initial service plan is developed by the JJS. From the "Forms Menu," click on the "Treat & Release Plans" section 3 and select the "Initial /Updated Service Plan" item A from the drop-down list.
This screen is supported by several links to other screens designed to perform auxiliary functions such as adding new offenses, a new contact, a new placement, or social history.

Residential Treatment Plan

All of the prior input has been related to documenting the history of a Client and providing a thorough analysis of the Client's current condition and environment. The Initial Service Plan has set goals for the Client and documented acceptance of these goals. The Residential Treatment Plans provide the logistical details for the accomplishment of these goals and also provides the form for follow-up. A case management section allows for updating based on current events as well as subsequent meetings with the Client (called a Participant on this form), as well as the other related parties (parents, CMO, provider, etc.).
Please note that the Strength and Needs and Risk Reassessment must be opened and saved individually as stand alone documents. You can access these forms at 3G and 3H within the form menu.

To begin, when you first start a JJIS treatment plan for a youth, even if you are starting with an Updated Treatment plan, (for a youth that has been in your program for some time) you will "Create a New Form". When this opens you will be requested to "select a form". Select the appropriate choice **then hit your TAB key**. This will set your form. Check your admission dates. If you are starting with an Initial Treatment Plan, you're Admission Date and your Report Start Date should be the same. Your report periods and months in care will automatically calculate by Tabbing through form. You will need to select your Judge as sometimes these changes frequently and we did not want these to be set in stone. Now this should look just like the current Word documents we use at FIA. Add information to your treatment plan as you normally would.

When you are finished, if you have an appointment, or whenever you need to leave working on your Treatment Plan, at the end of the document you will see a box to select either "Working", "Ready for Review", "Approved" or "Return for Edit". As a Treatment Leader you will select either Working or Ready for Review, a Supervisor will select either Approved or Return for Edit. Once a Supervisor puts in their Signature (password), and clicks on "Approved" there are no more edits able to be made.

As long as you are working on a plan, every time you want to open it up, click on the ***Edit*** button next to the plan you are working on. When it has been finished and approved etc… for your next quarterly you would then click on the "Copy Existing Form". It will bring up all your old data from your previous report but now you can make changes to it…Keep repeating until youth is discharged. **Also note that the needs and strengths, risk assessment only have to be completed at release**

This concludes the mandatory information that must be completed and/or reviewed. Once a case is assigned to the JJAU by the JJS, it can be done via E-mail notification. JJAU can then pull up a youth's record, review the information and assign a placement. The JJAU can notify the Agency via E-mail to inform them of the referral or assignment. You can open the case record and review it, determine acceptance or rejection and then notify the JJAU of your decision via E-mail. The JJS will then be able to review the treatment plans and incident reports etc. while their youth is in placement.

Spell Check To prepare your computer for spell check you must go to the task bar in the Internet and click on Tools, click on Internet Options, click on Security, click on Internet, click on Custom Levels, click on the Radial button that says" Initialize and script Active X to make safe," click OK, click Yes when it asks Are You Sure? This will never have to be done again

Department of Human Services

Juvenile Justice On-line Technology

JJIS

Training Manual

FOR JUVENILE JUSTICE
SPECIALISTS

Department of Human Services

Client Management Session

6.0 Hours

Objectives:

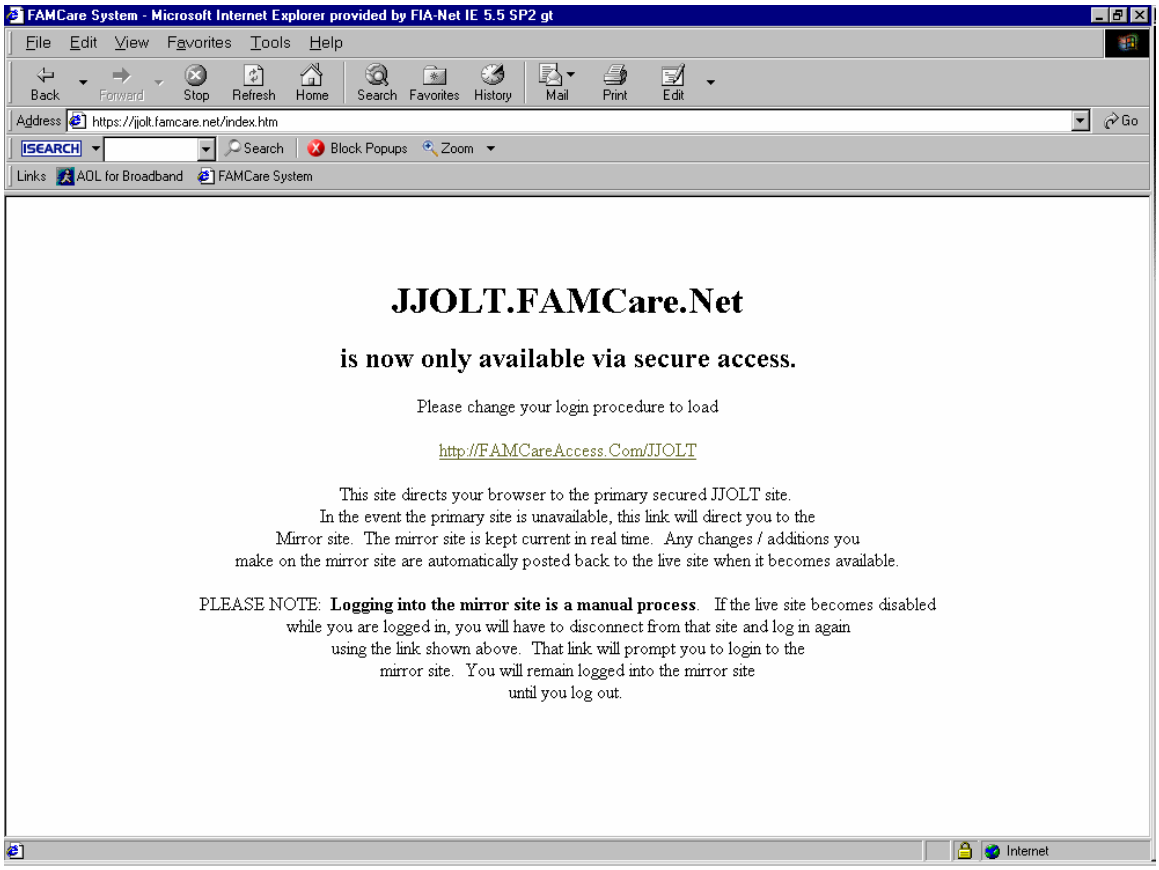
To ensure the operator can log on to JJIS and knows how to change passwords
To ensure the operator knows how to log off of JJIS
To give the operator an overview of the Client Menu
To ensure the operator knows how set up a Client record
To ensure the operator knows some of the key forms in JJIS

Content Overview

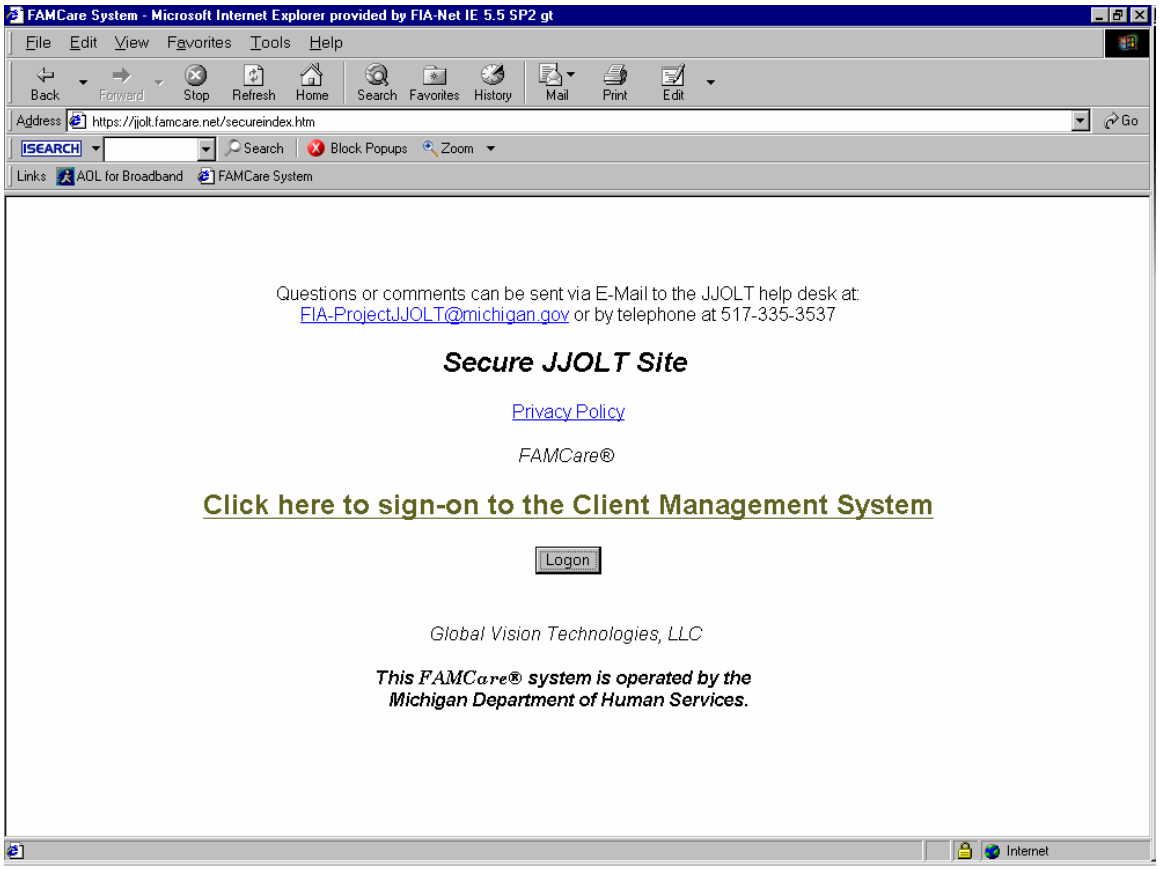
SESSION I
Pre-Logon Basics
Logon and Basic Navigation
Intake and Enrollment
SESSION II
Assessments and Treatment Plans
Incident and Escape
Misc. System Functions
Q&A

Session I - Pre-Logon Basics

Start/Programs/Internet Explorer Group wise E-mail DHS-ProjectJJOLT@michigan.gov
http:// FAMCareaccess.com/JJOLT or secondary: http://JJOLT.famcare.net
The screen below is the sign-on screen for JJIS® for DHS. Place your cursor on the line that states "Click here to sign on to JJIS" and click your mouse or hit the "Enter" button on the keyboard.



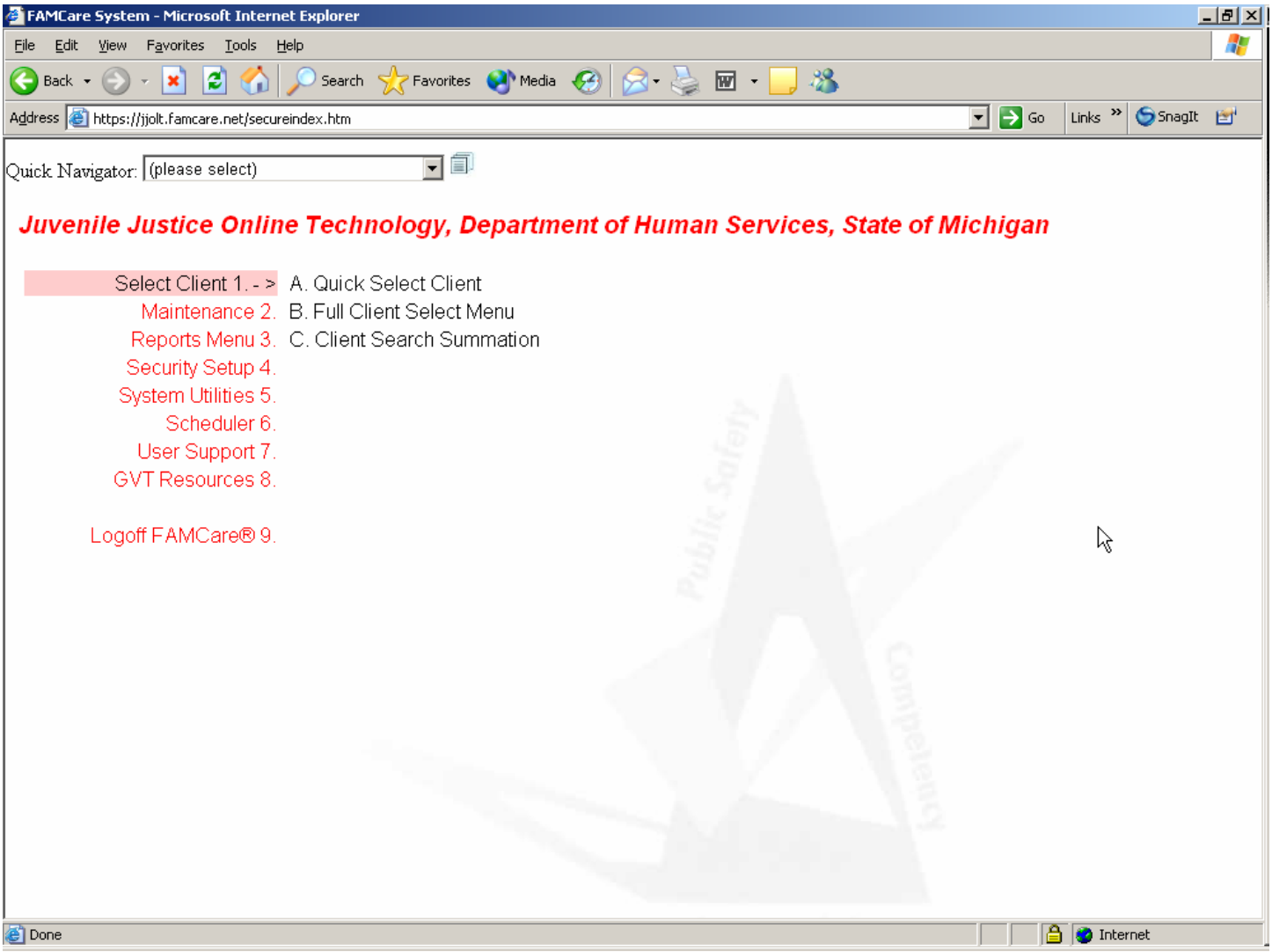
This brings up the sign-on screen, as well as a gray screen that contains the "Redistributable Code Agreement." Click on the "OK" button on that screen, which will then leave the sign-on screen, as shown below.



From this sign on screen, enter your user name (First-Last) and initial password you are given (123456 or abc123), **then go down to "New Password" and create your new password**. Confirm it, then click on the "Logon" button. This will produce the main master session menu (next page). **DO NOT CLICK ON LOGON UNTIL YOU CREATE YOUR NEW PASSWORD. YOU MUST CREATE YOUR OWN UNIQUE PASSWORD THE FIRST TIME YOU SIGN IN. ALPHANUMERIC, AT LEAST 2 LETTERS OR NUMBERS!**

You will then get a message that your password has been successfully saved.
Click to continue.

This will be the main screen you see when you sign on. This is a client specific program and you must search for your youth first before you can just add a new record.



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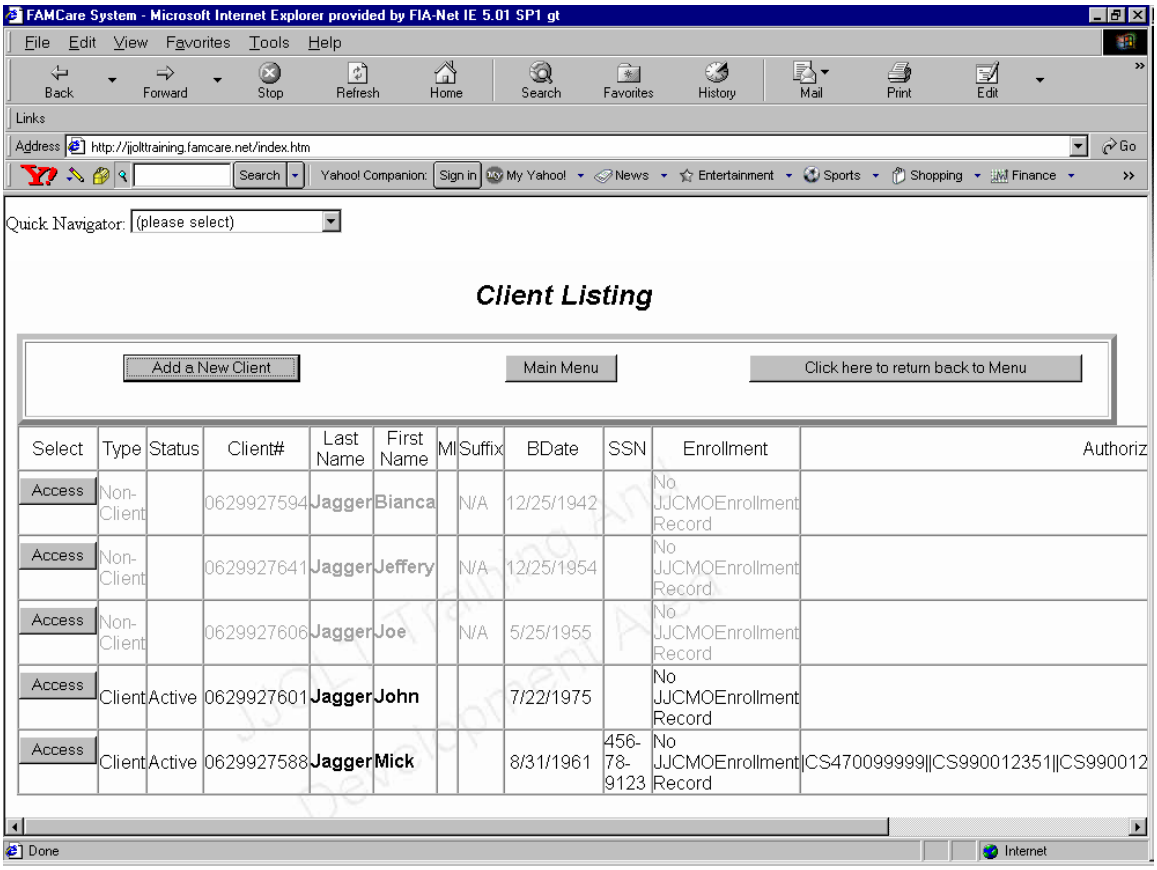
To access a specific Client, click on the "Access" button next to the Client's number and name. Check to make sure this is the same youth you are looking for by viewing the birth date and SSN, or you can go to the intake summary. If it is correct, this will bring up this youth's record and you can begin to add updated information.

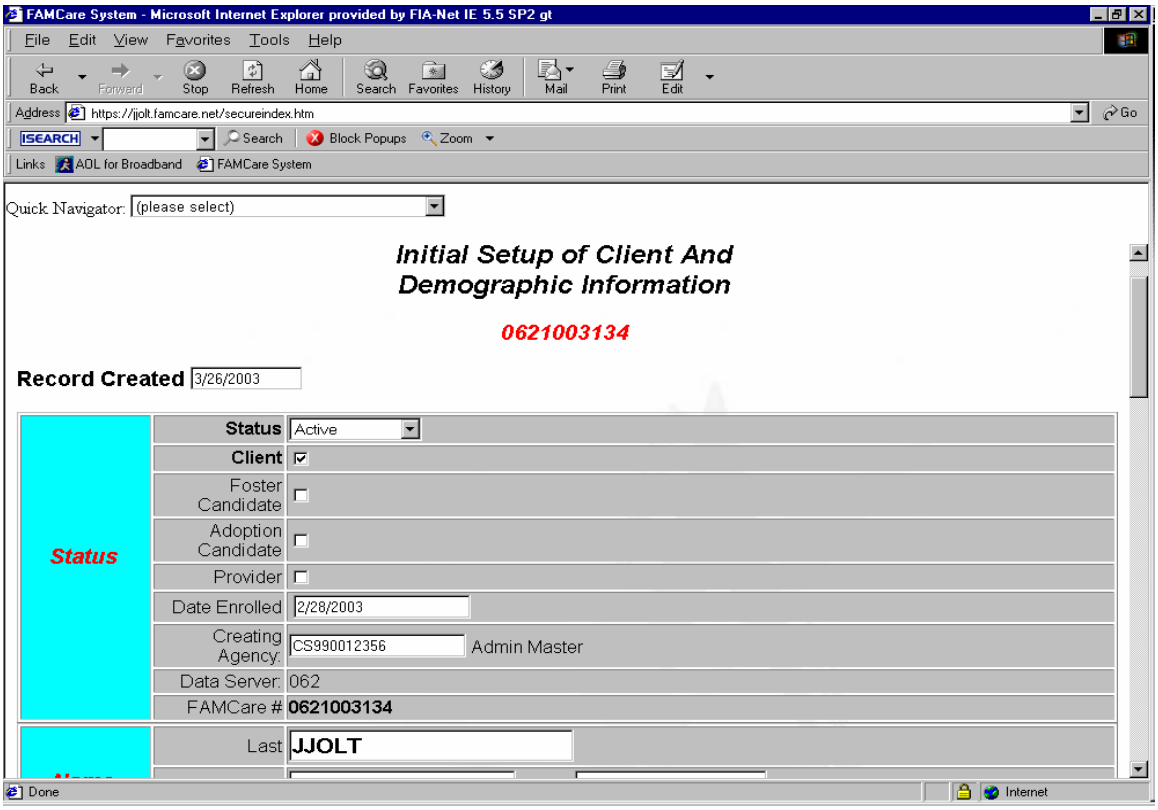


For Juvenile Justice Specialists- If you do not see the client on the list, this means that he/she has never been in our system before. All providers will see their clients.

Creating a Client Record For Juvenile Justice Specialists Only

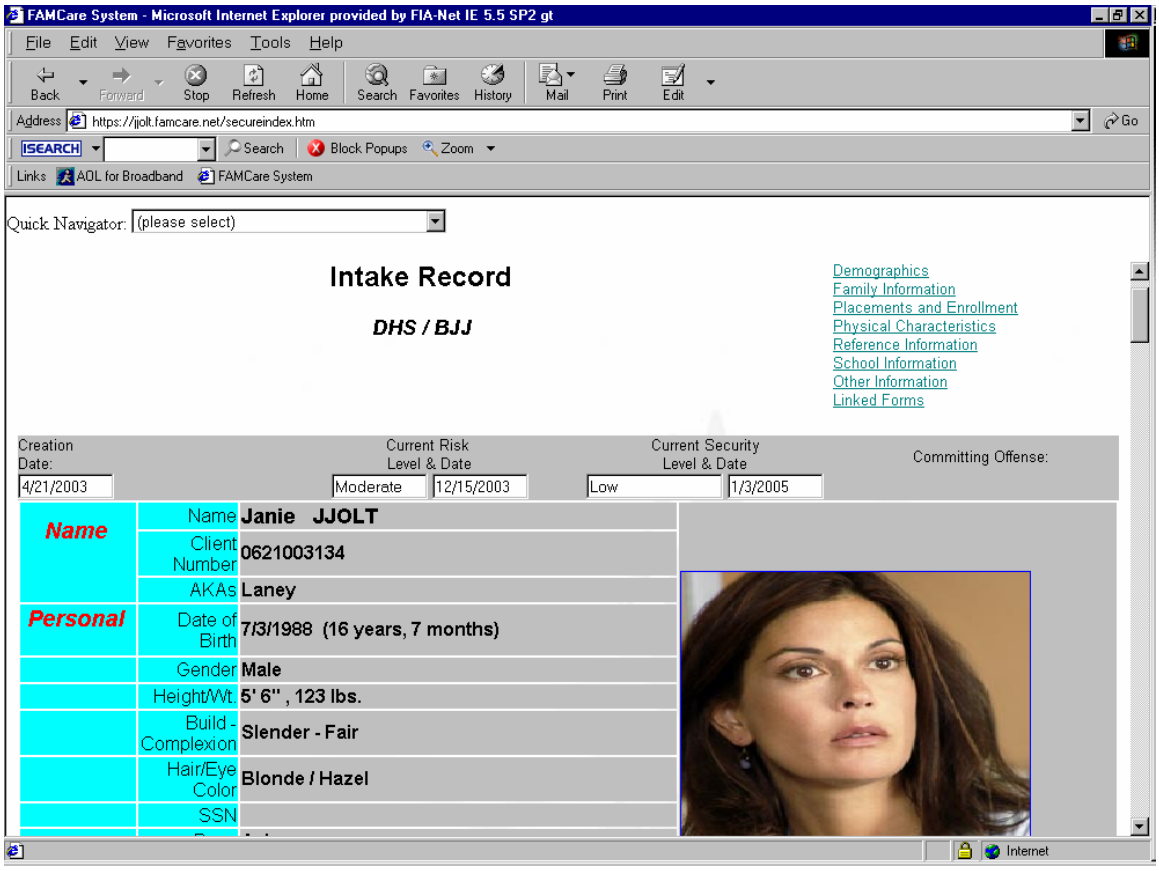
To create a new record, the minimum data entry is the client's first and last name, and date of birth. The system will automatically generate a Client Number that is unique to this new client.

At the *Initial Setup of Client and Demographic Information* screen, begin to add the information that you have.



When complete, sign the form with your password, and save it. **Always read your full screen and make sure that you scroll down to the bottom of each screen. Often, you will get a message to "click here to refresh"; that is the way your master record is updated. This screen says please wait while the forms load.**

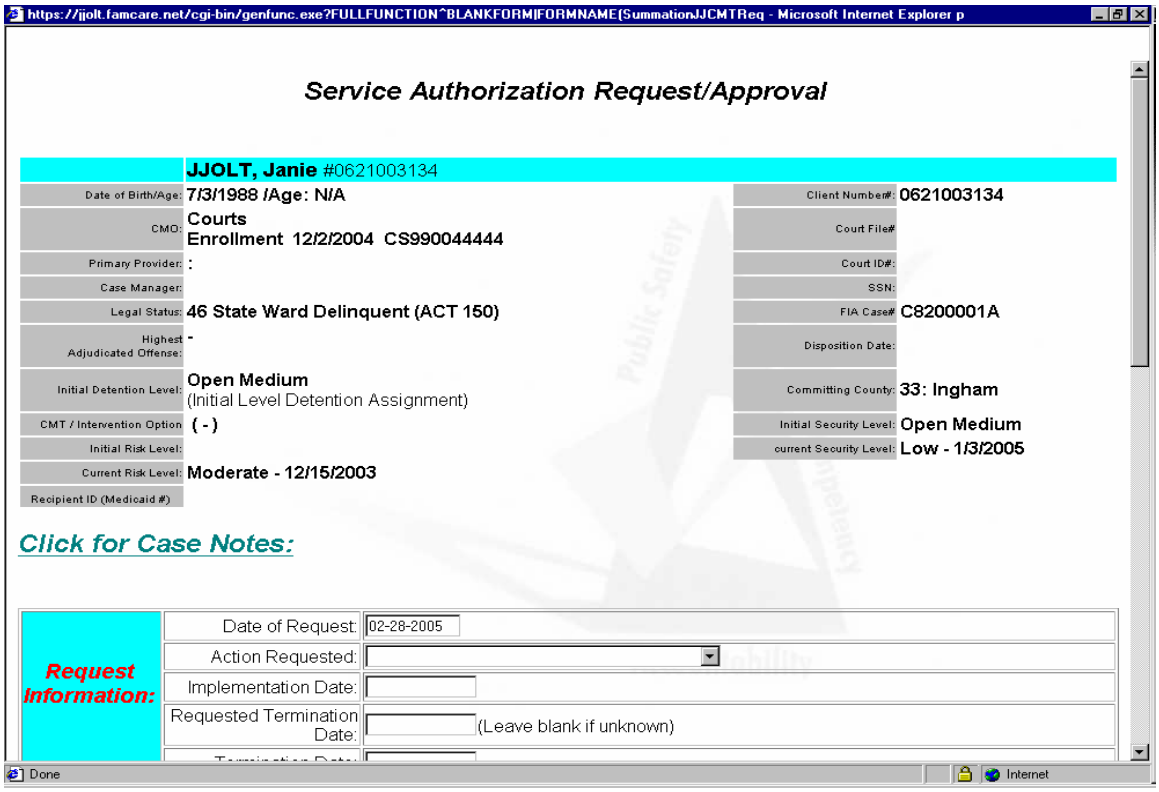
This brings up the "Intake Record" screen automatically. Since this form is so large, up to 10 seconds are needed for it to load. At this time, more data can be entered regarding client demographics, referral information, more of the client's legal, personal and family information, as well as history.



NOTE: Always make sure you also maximize the screen you are working on, this will ensure that you do not X out of your main screen, or close a form that you are working on without saving the information first.
Once the intake record has been saved, the "Save Confirmation" screen appears again. Select "Click Here to Continue." This generates the "Forms Menu" (shown below), which contains all of the forms for the new Client. This screen will be described in the next section.

SECOND: In the future you will add a Care Management Track for all youth other than those being referred to JJAU. Any Foster Care, SIL or Community Based program used must be tracked here. **The JJAU will currently do this section for those going to low, medium, or high secure facilities.** This is the main section relating to the activities required for a youth. The "Care Management Track Authorization Request" is an interactive form used by BJJ requesting any community-based program, a residential program, or by the JJAU for reviewing the record and placement of youth.

We will just briefly explain to you how the form works. From the "Forms Menu" for the Client, find the "Care Management Track" **(Form 7A**), and select the "CMT Authorization Request" item from the drop-down list.



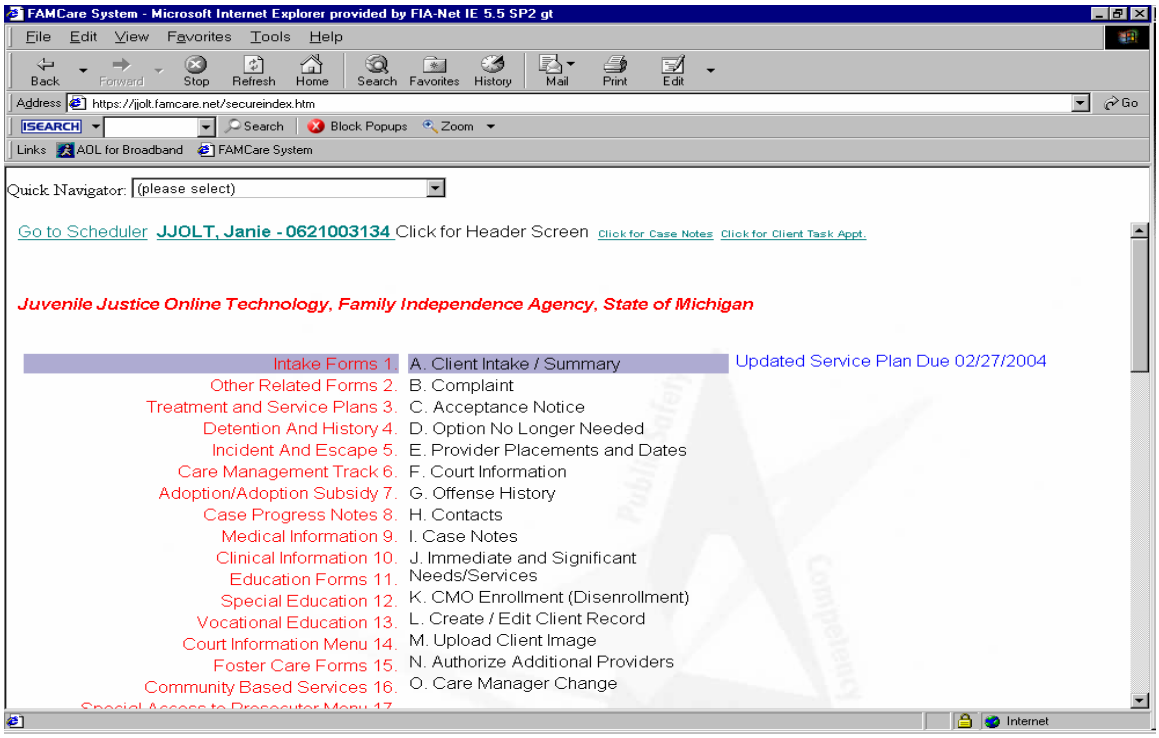
1. Action Requested = Change of CMT and/or Treatment Option or Initial Treatment CMT if this is a first time placement
2. Implementation Date = Date the Service is to begin
3. Termination Date leave blank.
4. Detention level –Leave blank/ or 03A Secure Residential Detention
5. CMT Requested = choose the appropriate action i.e. Closed Medium Residential
6. Intervention Option = Choose the appropriate response i.e. Sex Offender Treatment
7. Only the Primary Providers who have that type of programming will be among the choices i.e. Adrian, Summit Center, etc.
8. Authorization status is Active And Approved
9. Sign, Save and Refresh
10. This will also now automatically update the Placement History when you 'refresh' that section.

As a provider it will be your responsibility to inform the JJAU when you admit a youth into your facility. They will adjust the CMT and you will then have access to the complete case record.

Quick Navigator

At the top of the main screen is a "Quick Navigator" bar. Clicking on the field produces a small dropdown menu of the different areas for which the user has been granted access. This allows to more efficient movement around the system to avoid backing out of various screens to reach the main menu. You can return to the "Client Menu" screen to add another client, or you can go to the Main Forms menu for the client you are currently working on, or you can Log Off the system. **If you see this Quick Navigator you always know you are in the main screen, and this is how you move around the system. Do not use the X button at the top right hand side of your screen to close out, This will take you out of the system, and you must start all over, and you may lose information you were working on. The same is true for the 'Back" button, you may not save the information you were working on. Get in the habit of using the Navigator.**

Client Intake Forms (Menu Option 1-A)

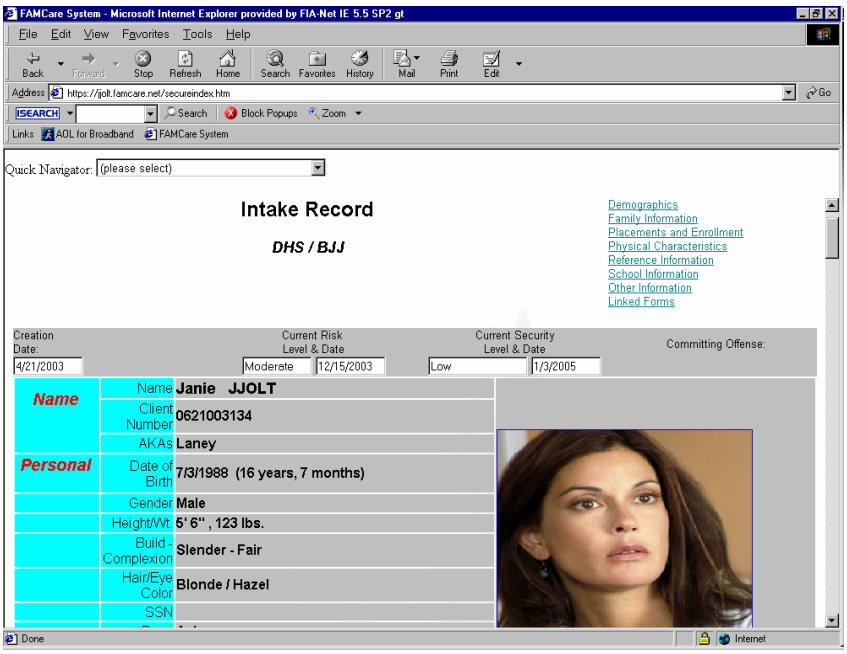


Forms Menu

The top of the page contains the Client's system-assigned number as well as name. The forms are organized into nineteen categories. To open a form, select the category on the left column and then click on it, which generates another list of forms. As each form is built, it automatically populates other required forms for this same Client. There are detailed "Help" screens that walk a user through the Client record building process. Select the proper "Go" button for the necessary help. We suggest you always begin in form 1A.

Building a Client Record

The "Client Intake / Summary," form continues for many pages. It is the critical form for entry into the system.
Note at the top of the form the Client's current Security and Risk Levels. These are pre-populated from risk assessments. There is also a box with the "Client's Highest Adjudicated Offense," which is pre-populated from "Offense History."
The top of the "Intake Record" form also shows links to various sections of the form, which are just shortcuts vs. scrolling down the page. The "Intake Record" also contains links to several other screens that supplement the basic Intake form.



Other Links on the "Intake Record"

Other links are described below, which allow for more complete data entry during the Intake process. These screens can also be accessed later through the "Forms Menu."
Regarding all the items in this section, once input is complete, click on "Save" to save the input or the "Back" button on the browser menu to cancel the input. An option exists on the "Save Confirmation" screen to also print out a hard copy of the record. Completion of this task and hitting the appropriate button on the "Save Confirmation" screen will take the user back to the "Forms Menu" for that Client.

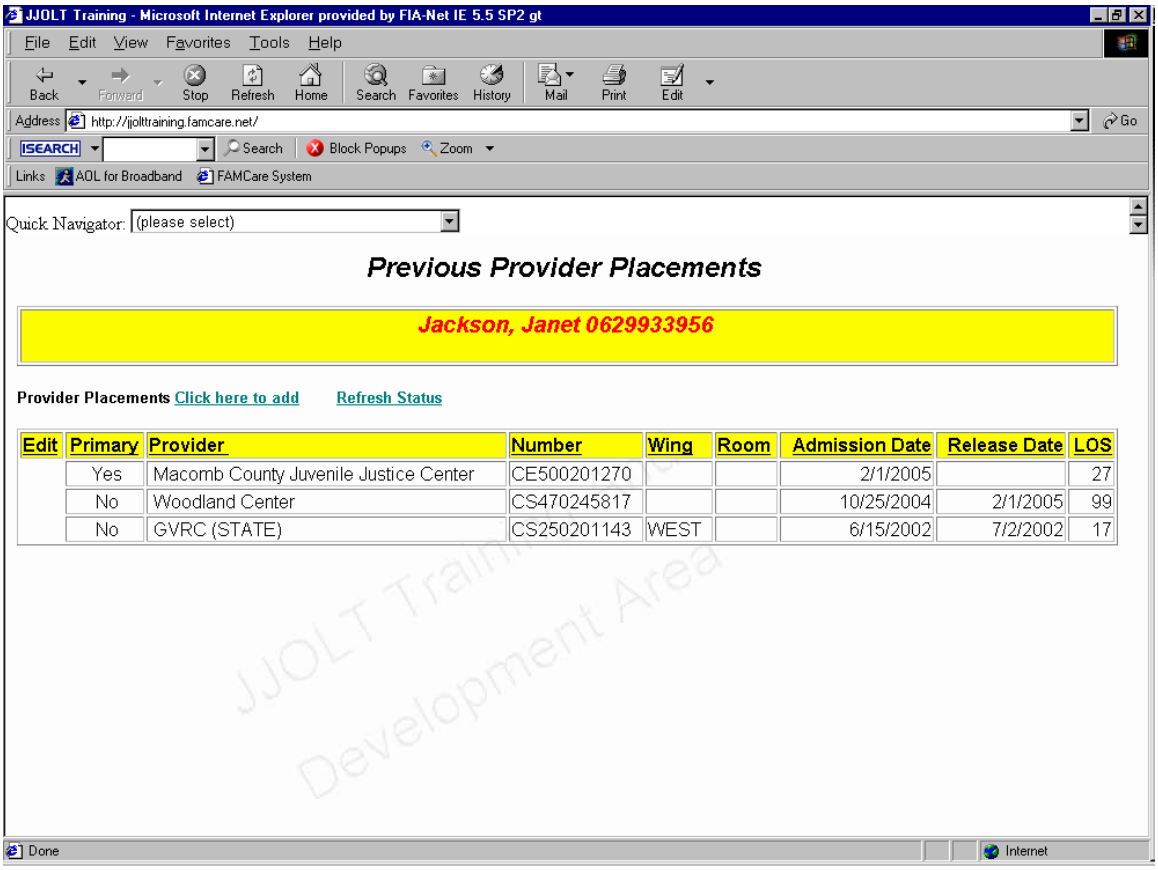
Parent/Guardian Information

The "Parent/Guardian Information" link provides significant information regarding all contacts involved with the Client and the treatment plan. Each Contact record will contain data regarding that person's relationship with the Client, privileges, role in treatment, demographics, insurance (if applicable) and possible restrictions regarding visitation. This screen is also referred to as "Contacts" and "Contact Detail" under the "Intake Forms" section on the "Forms Menu."
To begin

11. "click here to add"
12. This will bring up a Search Screen. Again, you must search for this contact, as they may already be in the system as a contact for another youth. Type in the contacts' last name (also using a wildcard Ja*). If they are in the system you can just click on their name and add the new information. If not you must click on the "Add a new contact to the master record"
13. Add all know contact information (name, DOB, Address, phone, etc.)Sign and save this form.
14. You then must add Relationship details. **It will only show up on the intake record as a Parent or Guardian if you have checked those boxes**. Also, if you check Main Domicile, you will change the youth's main record to the parents' address. **Also, it will only show up as Contact Restrictions if you check the appropriate box.** (Even if you add restrictions, but do not check the contact restriction box, no one will know there are restrictions.)
15. Sign the form, Save it and then you will get the confirmation screen. Scroll down until you see the Click here to refresh summary, and you will then return to your main Intake record, and the information added should be there.

Continue to Scroll through the Intake Record adding all information available. Case manager is the JJS worker. Committing County and Referring County, Committing Offense can be added several ways, but most often through the Court Information Screen, or Youth Acceptance notice.

At the bottom of the screen you will see links for Offense History, Medical /Psychological Information, medication Information etc. Add all information that you have available. If you do not have it, that is OK, only add what you know.



Previous Placements and Dates

The "Previous Placements and Dates" is used if this is a new youth record and you know some previous placement history, please add this. Always follow your screen instructions. Otherwise, all other placement history is connected through the CMT authorization process through the JJAU.

Offense History

This form is self-descriptive, allowing for input of the Client's offense history. For each Offense, and Adjudication date and status must be filled in.

Physical/Psychological Information

This form is self-descriptive, allowing for input of the Client's current physician and psychiatrist, the date of the last physical exam, and notes. A link is also provided to the Medications and Immunizations forms.

Medication

The "Medication" form is used to document all medications prescribed for the client, including prescription number, pharmacy name, referring physician, dosage and any special instructions. Each type of medication requires a separate record, which can also be edited. This section is required for all agencies to keep updated. Any time a youth has a medication change, the Group Leader, Medical staff, or whoever is assigned must go in and complete this information. If a client refuses to take their medication, this can be addressed in an Incident Report, which will link itself to the Medical Section in JJIS

Immunizations

The "Immunizations" form is used to document any immunizations that the Client has received and also to input those that are necessary but not yet received (or expired).

Immediate and Significant Needs and Services to be Provided

This form consists of text boxes for special notes regarding the physical needs of the Client and/or emotional needs of the Client and parent.

Saving Information

At the end of your Intake Summary, one last time you must sign and save your complete form. The computer does not know that you are actively working on a record unless you are hitting any save button at least hourly. If you have not done this, you may get kicked out of the system and not even know it, thus none of your information will be recorded.

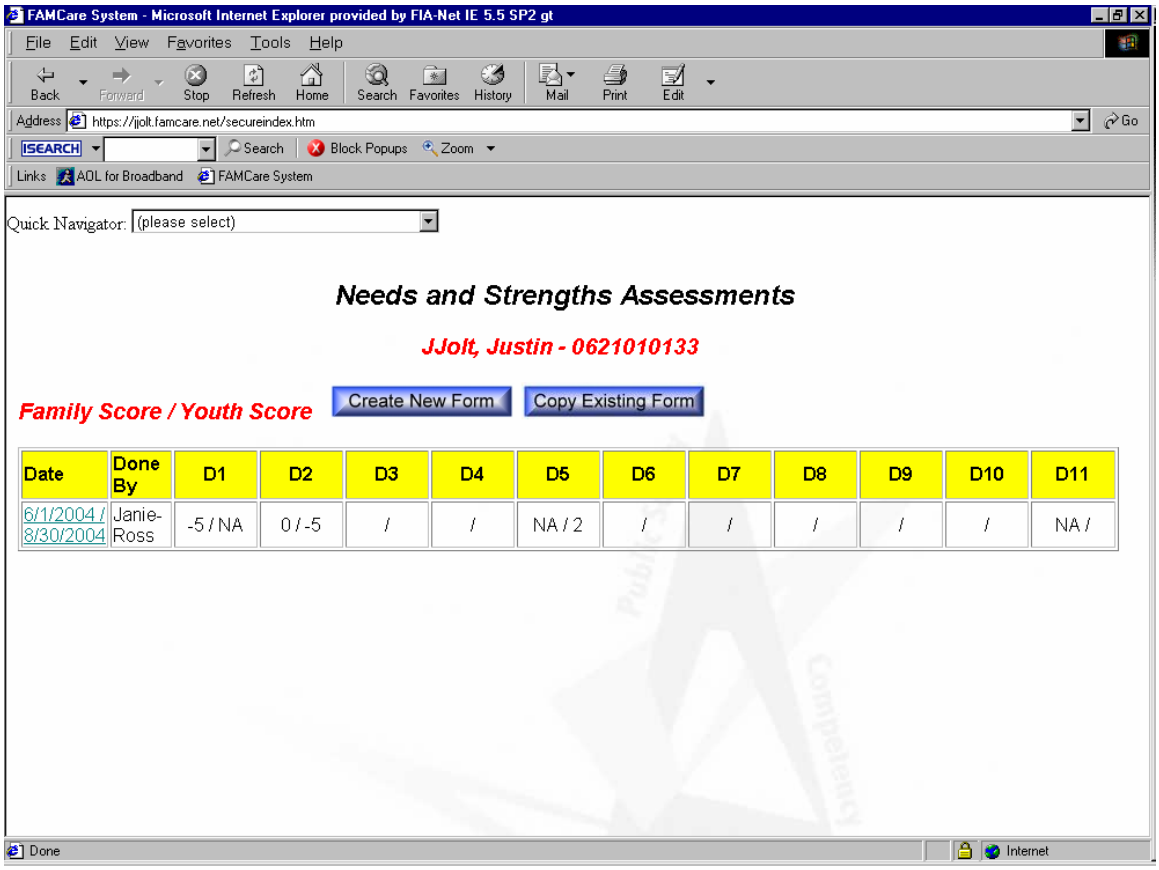
Make sure you are saving your information regularly!

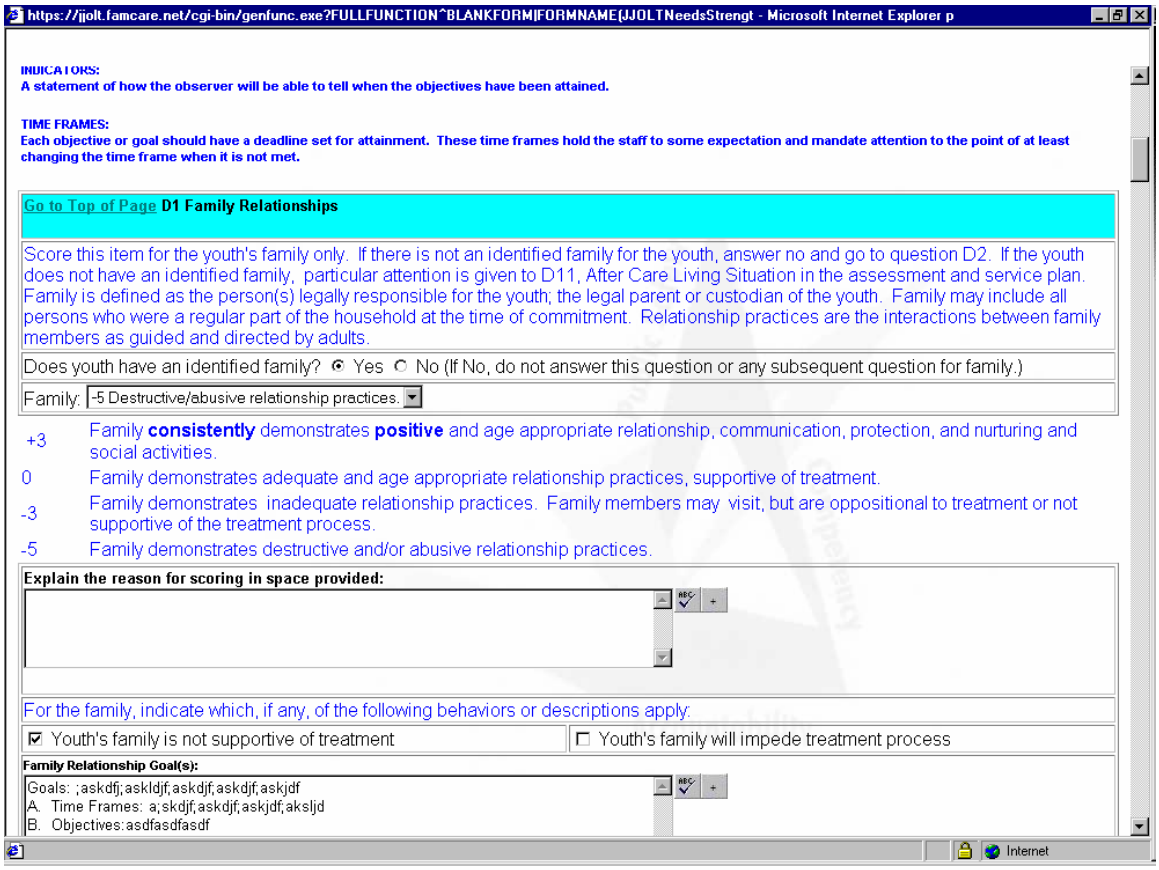
Once the "Intake Record" has been completed, the Client's assessments are entered next. The "Risk/Needs Assessments" section on the "Forms Menu"(2 C<D<E<F<G) contains the assessment forms that are available for various purposes.

Client Menu #2-E. **Strengths/Needs Assessments**

One of the key forms in this section is the "Strengths/Needs Assessment" form, which is used to develop the Initial and Updated Service Plans. (NOTE: This screen will also be revisited to update the Residential Treatment plans or develop a Release plan.) Click on this line item to select it from the menu to create a stand-alone document. This will take you to the next screen to select a new form or to select a form with the last-inputted forms data pre-populating it, or edit an existing form. You can also reach this form by selecting 4A and creating your Initial or Updated Service Plans.

Selecting any option will produce the "Needs and Strengths Assessment" form, as shown below. It looks just like our current Word document. This screen allows the user to document each tracking domain for the Client, calculate the Client's and family's score, and set goals for each domain.

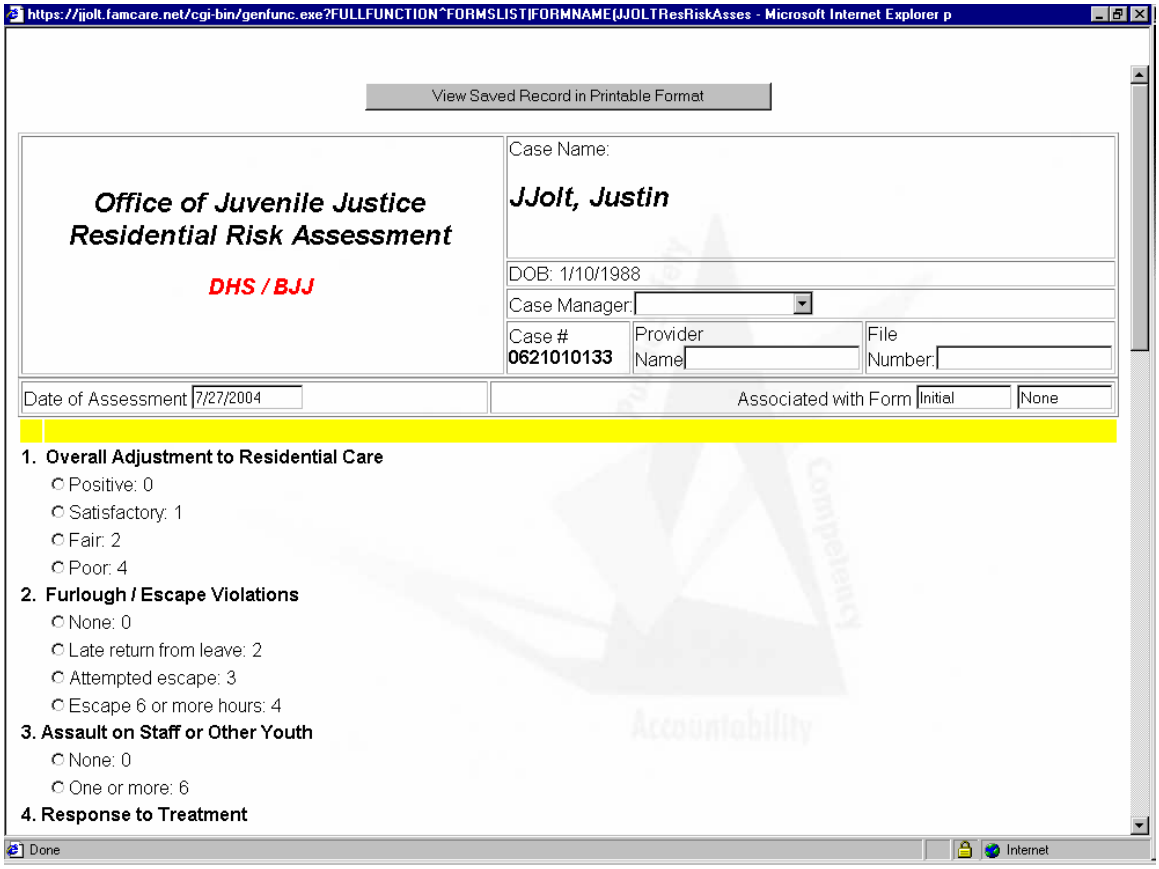




Both the Client and Family will be calculated. Then the form can be saved. When data entry is complete, click on the "Save" button.

Once the record has been saved, the "Save Confirmation" screen appears. This has the same functionality as the "Save Confirmation" screen for the "Intake Record" – a printout can be produced or the user can go directly back to the "Strengths/Needs Assessment" screen to make further modifications to the Client's record.

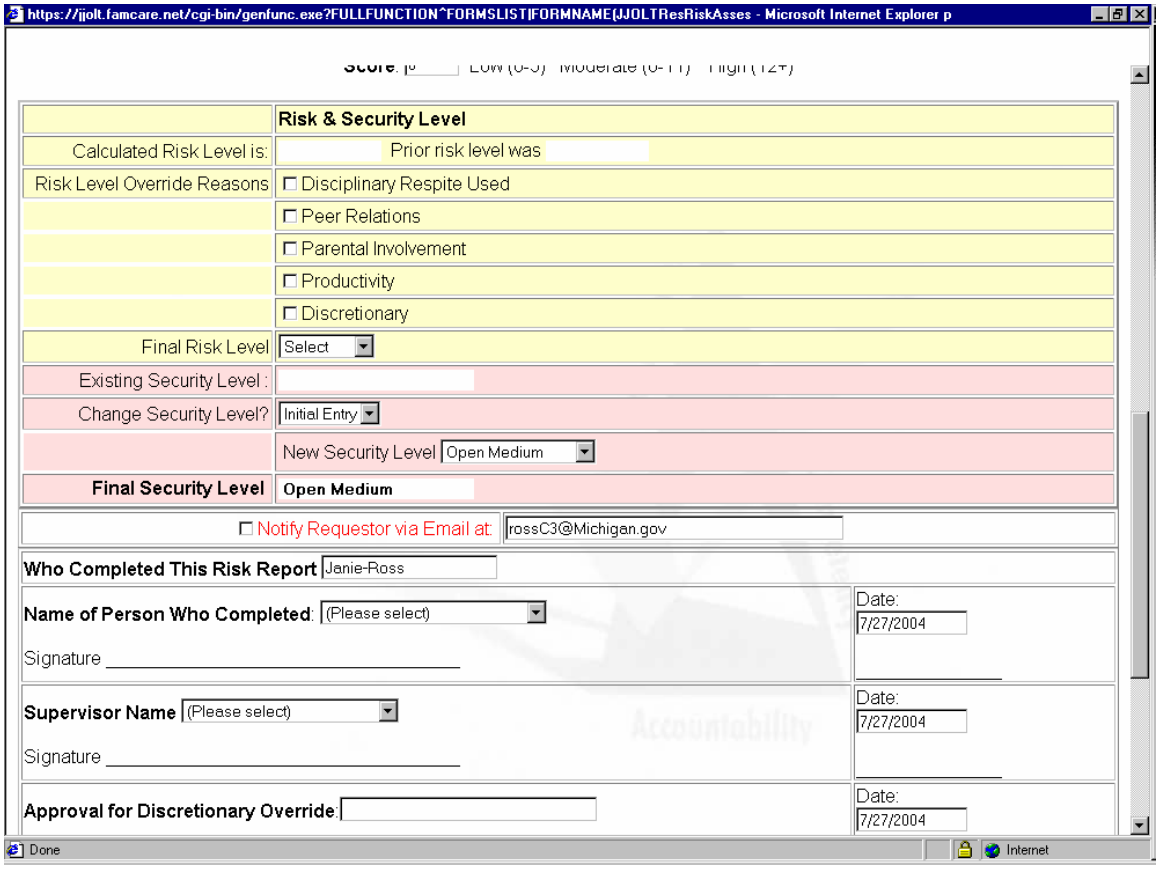
.**Security Level Matrix for Re-Offenders**



NOTE: As with the other risk forms in this section, the risk scores will be calculated each time the information is input and updated

Juvenile Classification and Assignment

The “Juvenile Classification and Assignment” form is created by the JJS and utilized by JJAU and Treatment Programs to determine a Client’s initial risk and security classification. Again, this form looks just like our current word document.
NOTE: As with the other risk forms in this section, the risk scores will be automatically calculated each time the information is input and updated. However, in this case, this is a one time only form The Highest Adjudicated Offense will then automatically pre-fill the security level, and then you can scroll down and fill in an override if necessary.



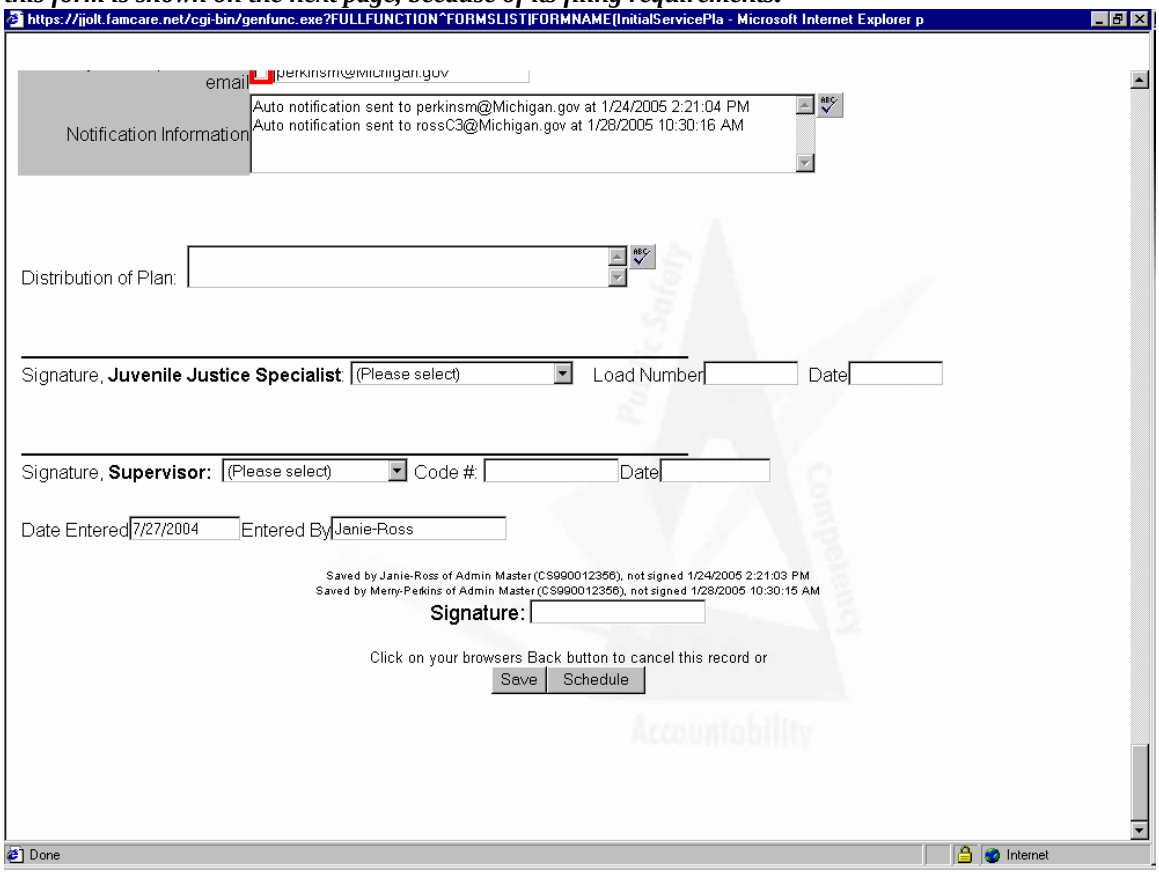
Initial and Updated Service Plans

Once the Client has been entered into the system and has been assessed, an initial service plan is developed. From the "Forms Menu," click on the "Treat & Release Plans" section 4 and select the "Initial Plan of Care" item A from the drop-down list.

As with the "Strengths/Needs Assessment" form, select either the "New Form," "Add a new form using last form's data as a start" or "Edit" button next to an existing record. This screen is supported by several links to other screens designed to perform auxiliary functions such as adding new offenses, a new contact, a new placement, or social history.

Once this screen has been completed, the user can save the record or move on to two other screens, "Needs and Strengths Assessment" and/or "Initial Plan of Care, Page 3" by selecting the links at the bottom of this screen.

The "Needs and Strengths Assessment" is the same form as shown under the "Assessments" section on the "Client Access Page," as shown on the previous pages. The "Initial Plan of Care, Page 3" link continues the Initial Plan of Care input. The bottom of this form is shown on the next page, because of its filing requirements.



This form must be printed, so that the youth, parent(s)/guardian(s) and supervisors can sign it. Place the signed copy in the Client's file. Once you complete the form, notify your Supervisor so they can review it. If both agree it is complete, you open it, sign it and then your supervisor opens it and signs it. Now it is considered signature locked and no edits or changes can be made to that form.

Residential Treatment Plan (view only access)

All of the prior input has been related to documenting the history of a Client and providing a thorough analysis of the Client's current condition and environment. The Initial Service Plan has set goals for the Client and documented acceptance of these goals. The Residential Treatment Plans provide the logistical details for the accomplishment of these goals and also provides the form for follow-up. A case management section allows for updating based on current events as well as subsequent meetings with the Client (called a Participant on this form), as well as the other related parties (parents, CMO, provider, etc.).
Several sections and links are on this form to allow for further updating of contacts, court proceedings, needs/strengths, risk assessment, and progress toward goals. Note that security and risk levels are updated as well, as indicated in the header. The main difference in the Updated form is the inclusion of a "Court Summary" section at the bottom that documents the Client's current behavior and attitudes and a recommendation for continued custody or a release plan.
This form contains links to several other forms for updating. These include "Contacts," "Offense/Court Information," "Provider Placements," "Needs and Strengths Assessment," and "Residential Risk Assessment." Clicking on any of these links produces a screen, which can be updated or just referred to. Please note that each of these forms must be closed and saved individually if they are opened, before the "Treatment Plans" can be saved and printed.
You must remember that until you are notified that a youth's treatment plan is completed, if you chose to check on you youth's progress, you may only see a "work in progress"

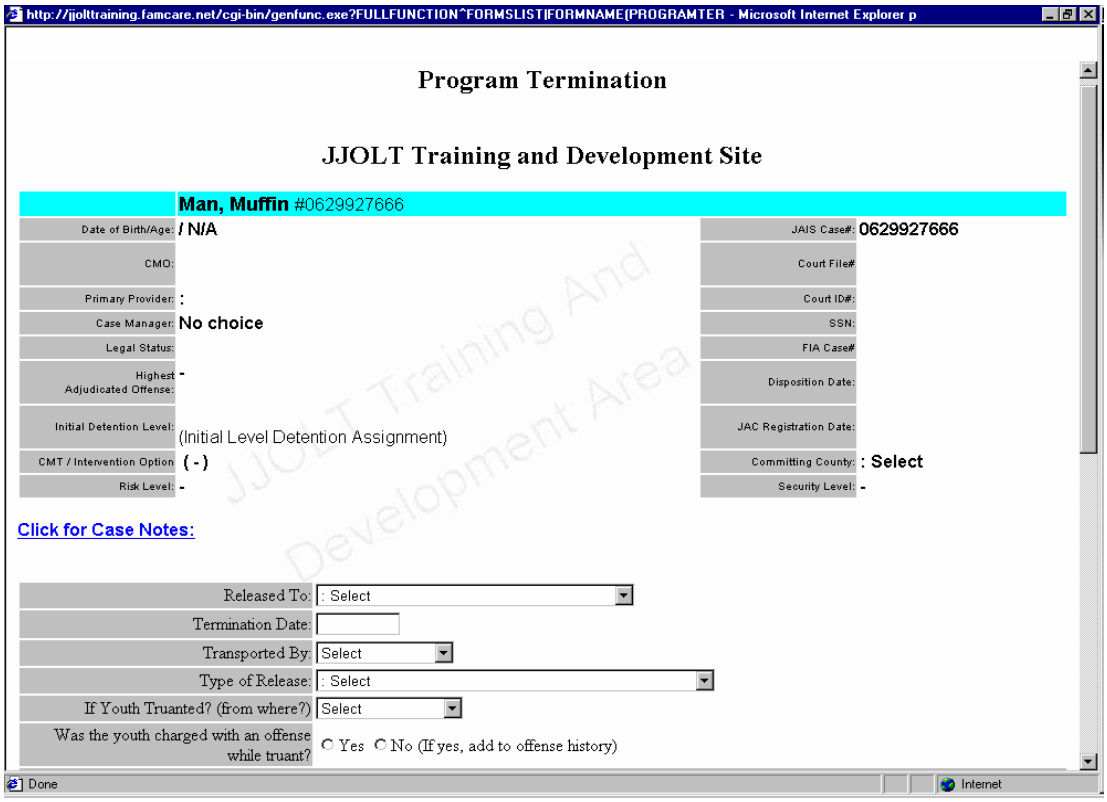
Disenrollment

This concludes the mandatory information that a JJS must complete and/or review. Once a case is assigned to the JJAU, it can be done via E-mail notification. JJAU can then pull up a youth's record, review the information and assign a placement. The JJS will then be able to review the treatment plans and incident reports etc. while their youth is in placement.

When a youth is released from the State of Michigan-FIA supervision you must then disenroll a client's record. Go to the CMO section of the Intake Record.

1. Click here to enroll/disenroll
2. It will inform you that you must complete a Program Termination. Click OK
3. Fill in as much information as possible, especially released to and type of release. Sign and Save. You will return to the disenrollment form. Enter transaction date (date of release from FIA) Disenrollment is already pre filled.

Sign and Save. Youth's record will now be made inactive and disenrolled



Department of Human Services

Juvenile Justice On-line Technology

JJIS

Training Manual

Residential Treatment Plan

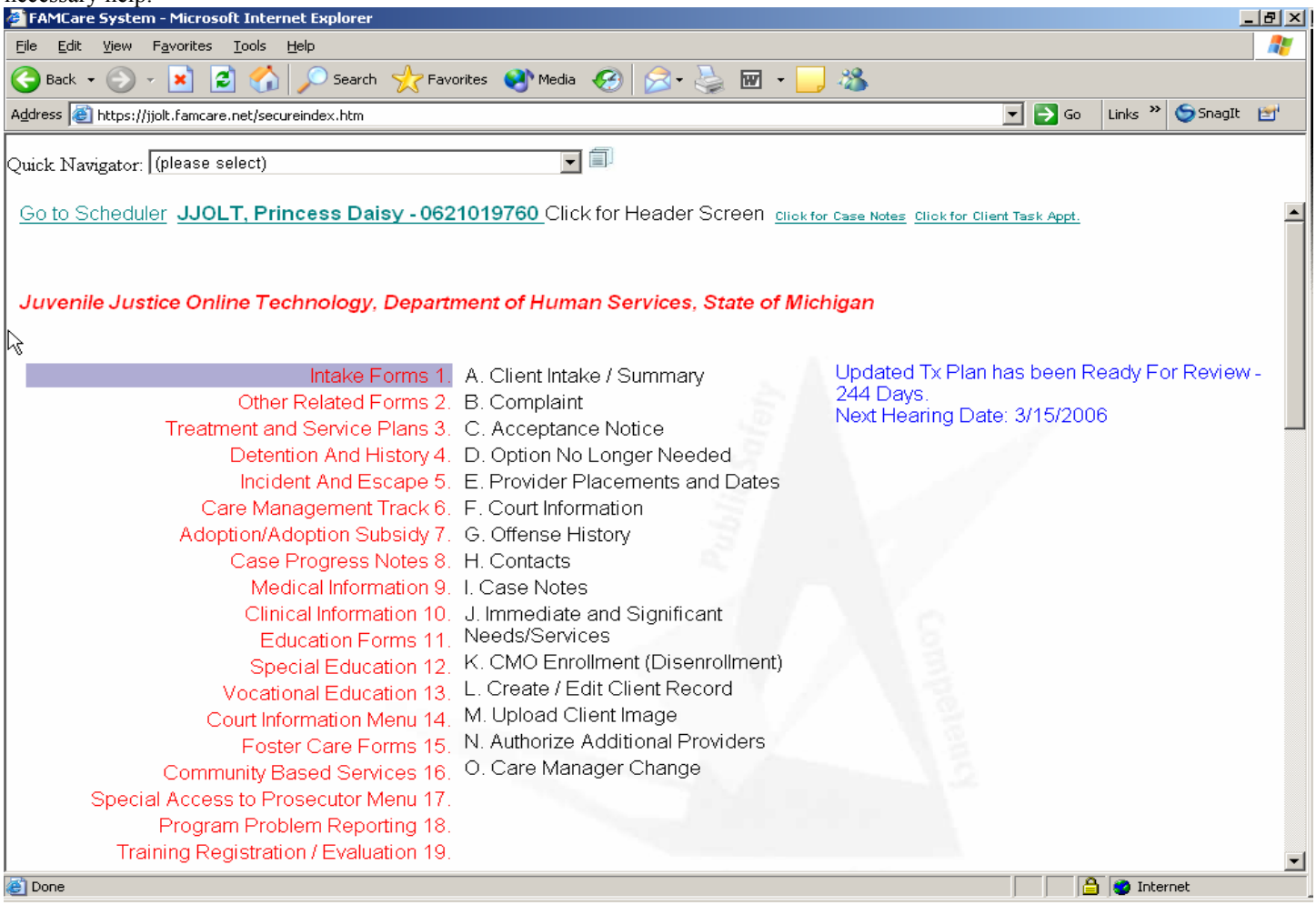
Department of Human Services

Client Intake Summary (Menu Option 1-A)

Forms Menu

The top of the page contains the Client's system-assigned number as well as name. The forms are organized into categories. To open a form, select the category on the left column and then click on it, which generates another list of forms. As each form is built, it automatically populates other required forms for this same Client.

There are detailed "Help" screens that walk a user through the Client record building process. Select the proper "Go" button for the necessary help.



Quick Navigator

At the top of the main screen you will also see a "Quick Navigator" bar. Clicking on the field produces a small dropdown menu of the different areas for which the user has been granted access. This allows to more efficient movement around the system to avoid backing out of various screens to reach the main menu. You can return to the "Client Menu" screen to find another client, or you can go to the Main Forms menu for the client you are currently working on, or you can Log Off the system.

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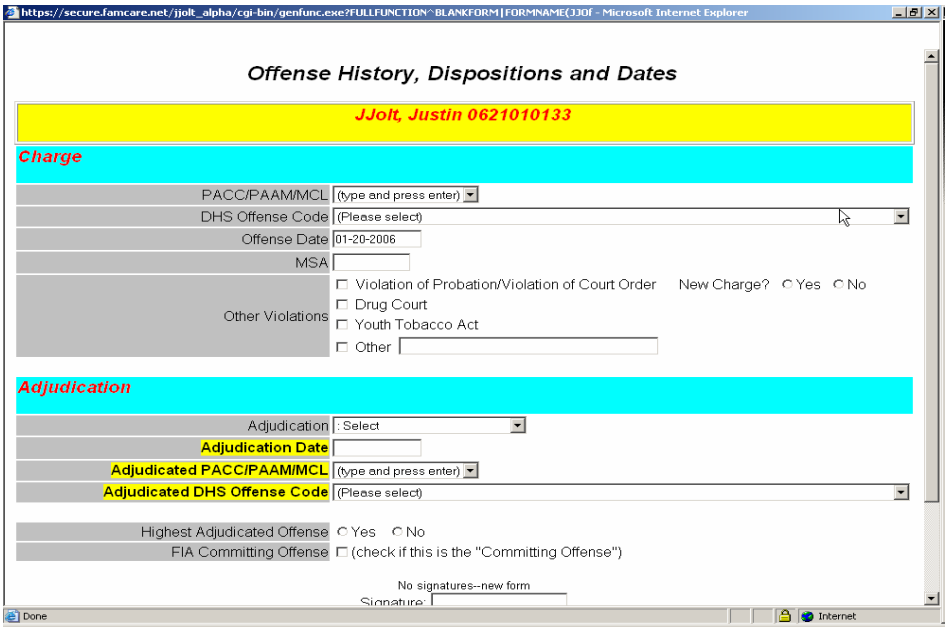
If you accidentally X out of the system, you will have to log back in to JJIS, sign in again, restate your password, and search for the youth record that you were working on.

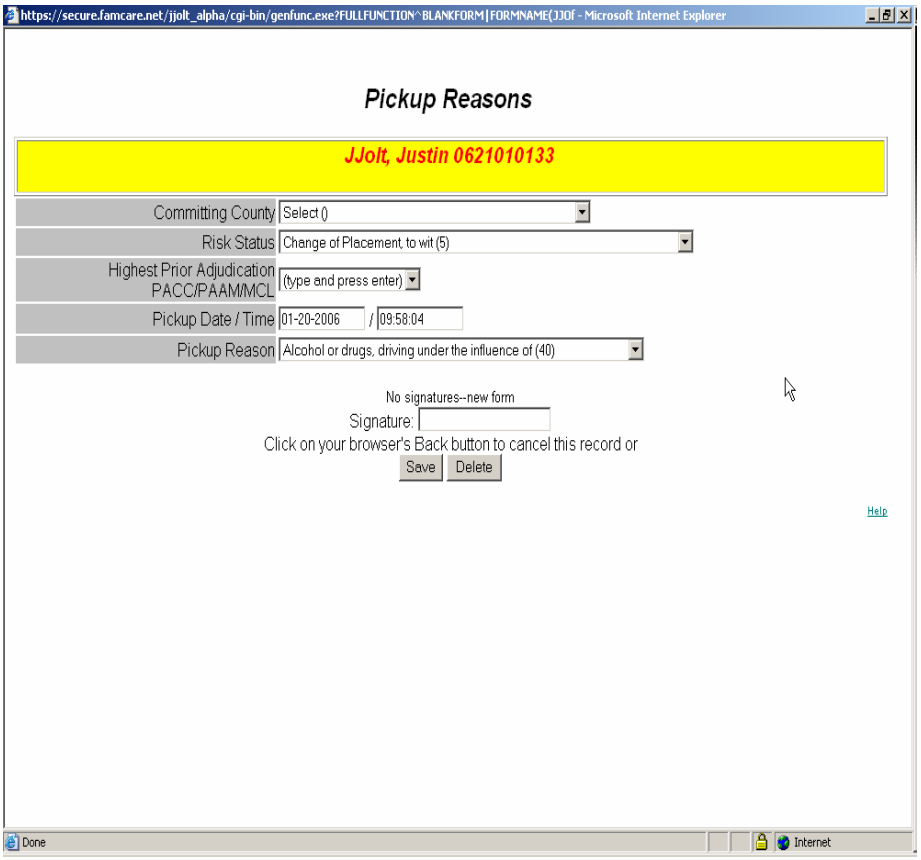
<u>There are some additional ticklers to alert the user which data is missing, next treatment plan due date, etc. these ticklers are located at the right, with blue lettering.</u>

As you are working in the system, often you will be adding information to "Forms within Forms". Look for your Quick Navigator, if you do not see it you can use the X button to close out of that particular form.

Any time you add information to a form; you must **SAVE**, and then follow your screen buttons to refresh. If adding multiple information use **quick saves,** and then saves. If you are just viewing a form you can X out of it if you have not added any information.

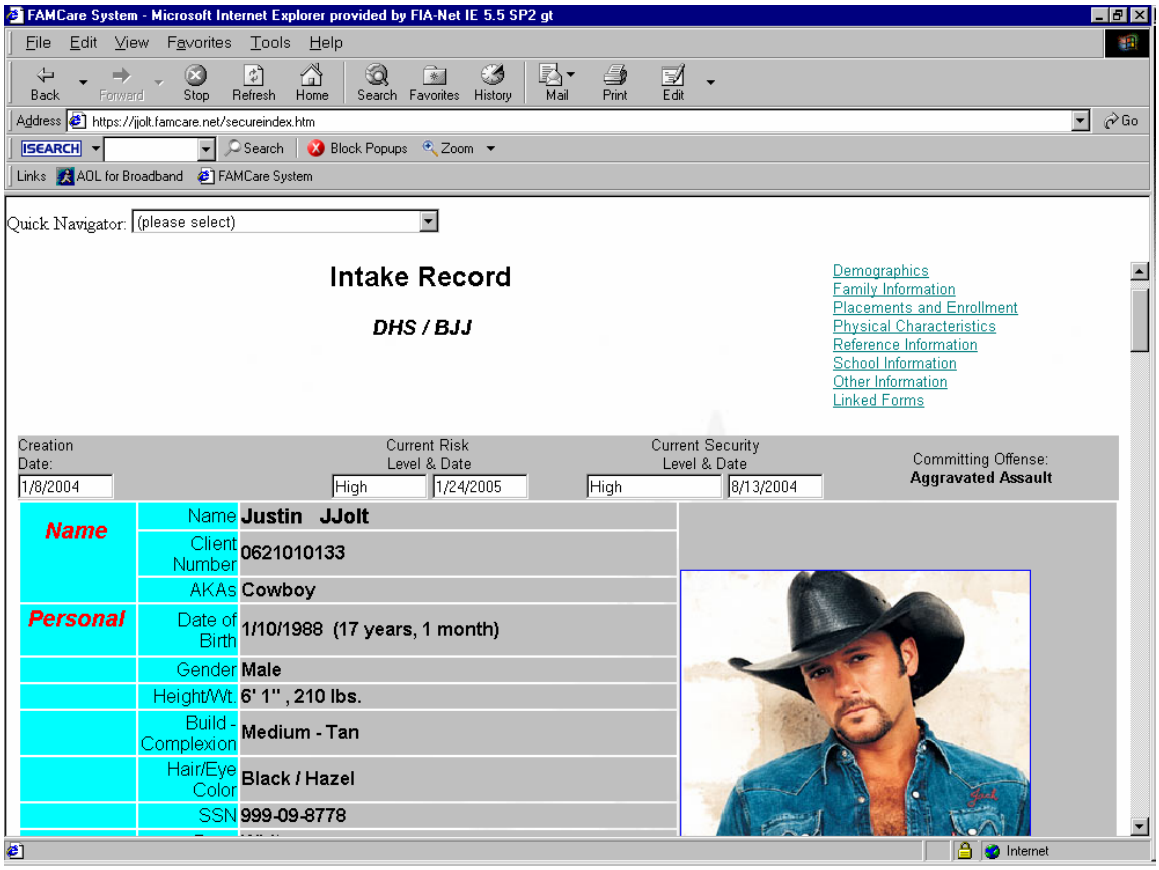


For Detention



Building a Client Record

The "Client Intake / Summary," form 1A continues for many pages. It is the critical form for entry into the system.

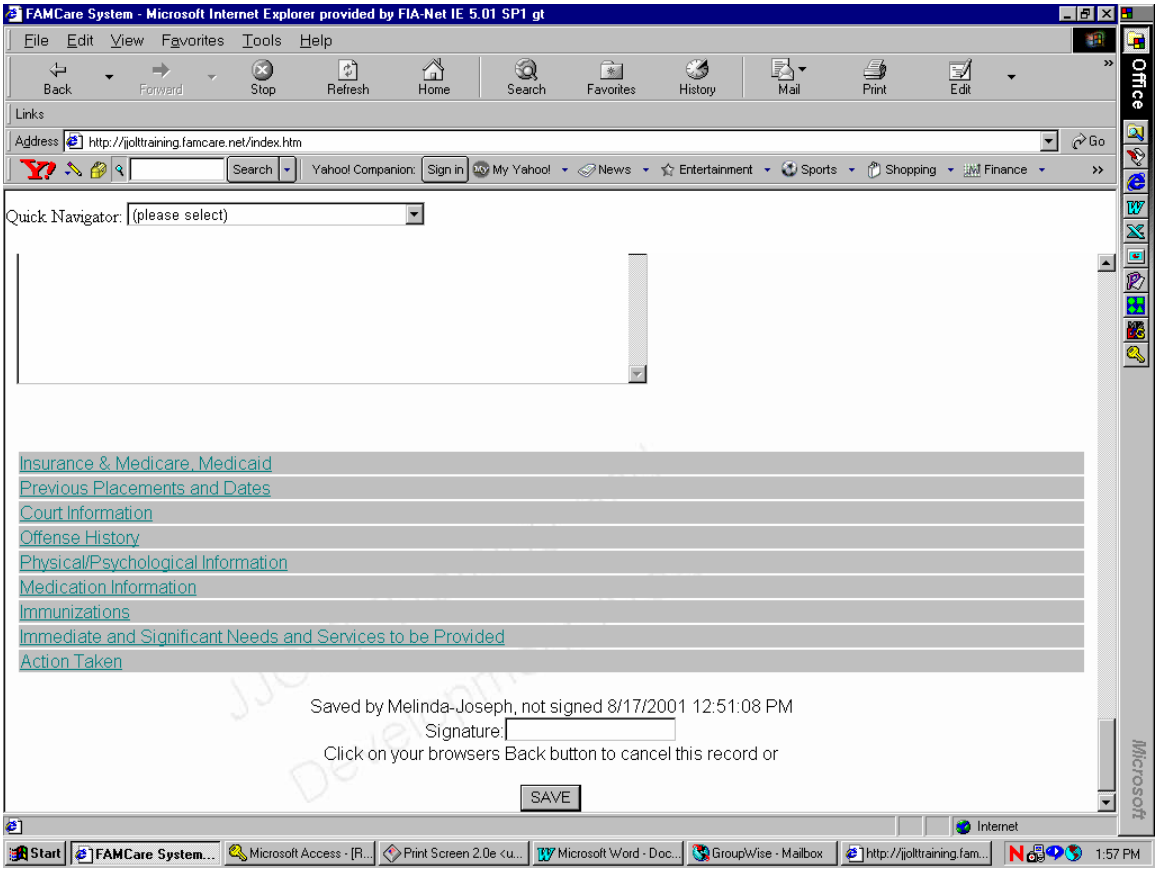


Note at the top of the form the Client's current Security and Risk Levels. These are pre-populated from risk assessments. There is also a box with the "Client's Highest Adjudicated Offense," which is pre-populated from "Offense History."

The top of the "Intake Record" form also shows links to various sections of the form, which are just shortcuts vs. scrolling down the page. The "Intake Record" also contains links to several other screens that supplement the basic Intake form.

Other links are described below, which allow for more complete data entry during the Intake process. These screens can also be accessed later through the "Forms Menu."

Regarding all the items in this section, once input is complete, click on "Save" to save the input or the "Back" button on the browser menu to cancel the input. An option exists on the "Save Confirmation" screen to also print out a hard copy of the record.



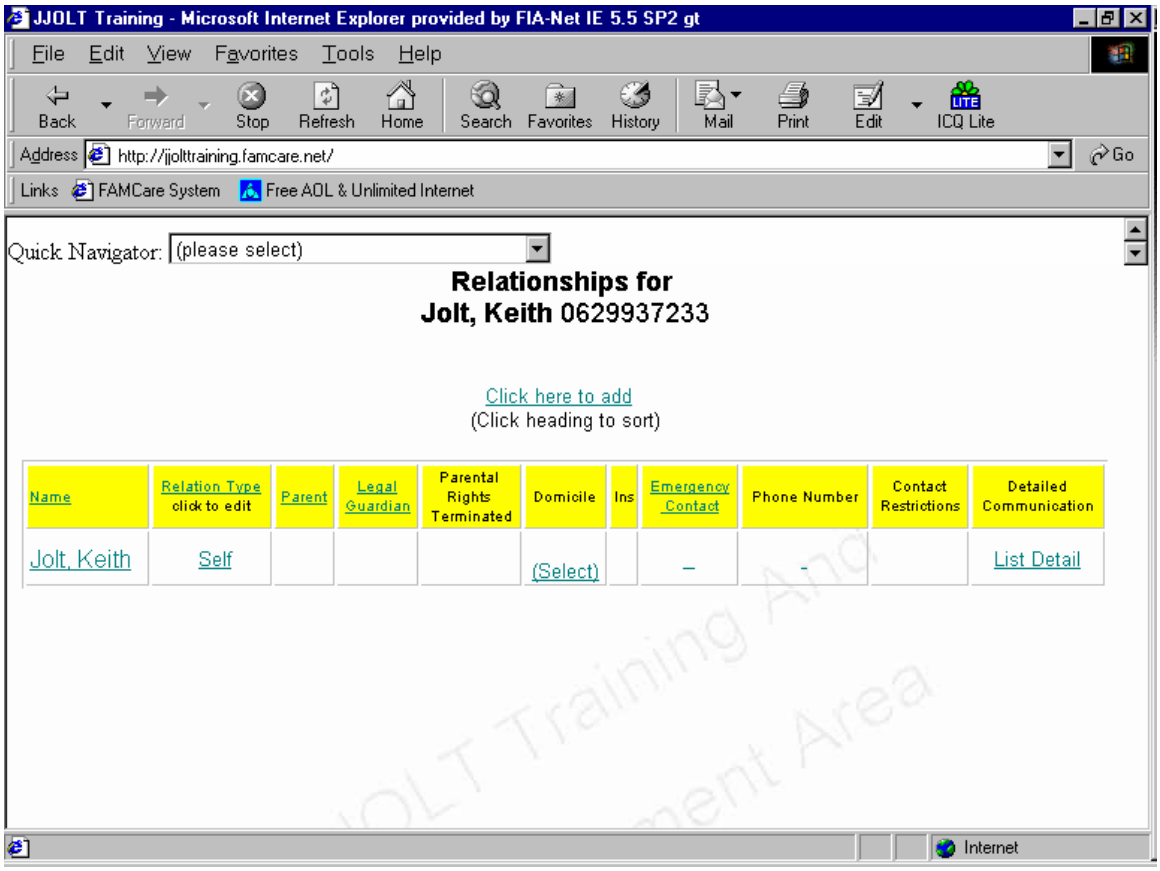
Completion of this task and hitting the appropriate button on the "Save Confirmation" screen will bring the user back to the "Intake Summary" for that Client.

Parent/Guardian Information or Contacts

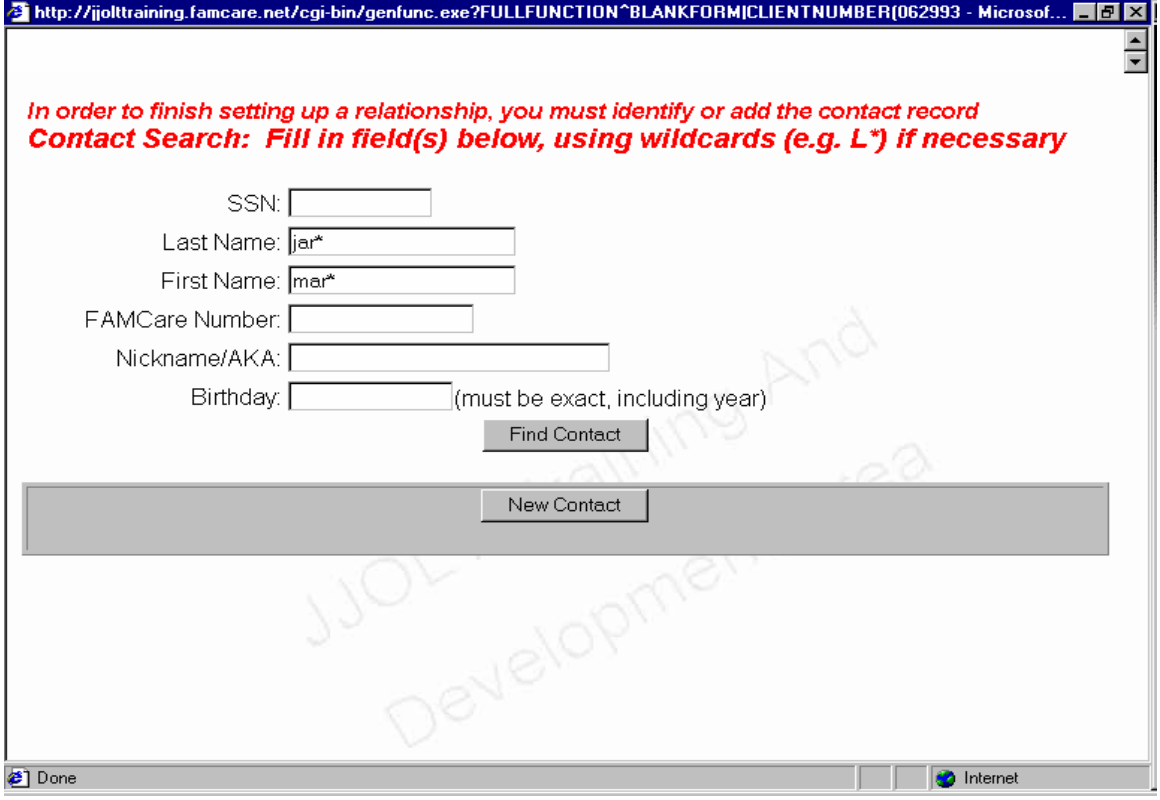
The "Parent/Guardian Information" link provides significant information regarding all contacts involved with the Client and the treatment plan. Each Contact record will contain data regarding that person's relationship with the Client, privileges, role in treatment, demographics, insurance (if applicable) and possible restrictions regarding visitation.

To begin

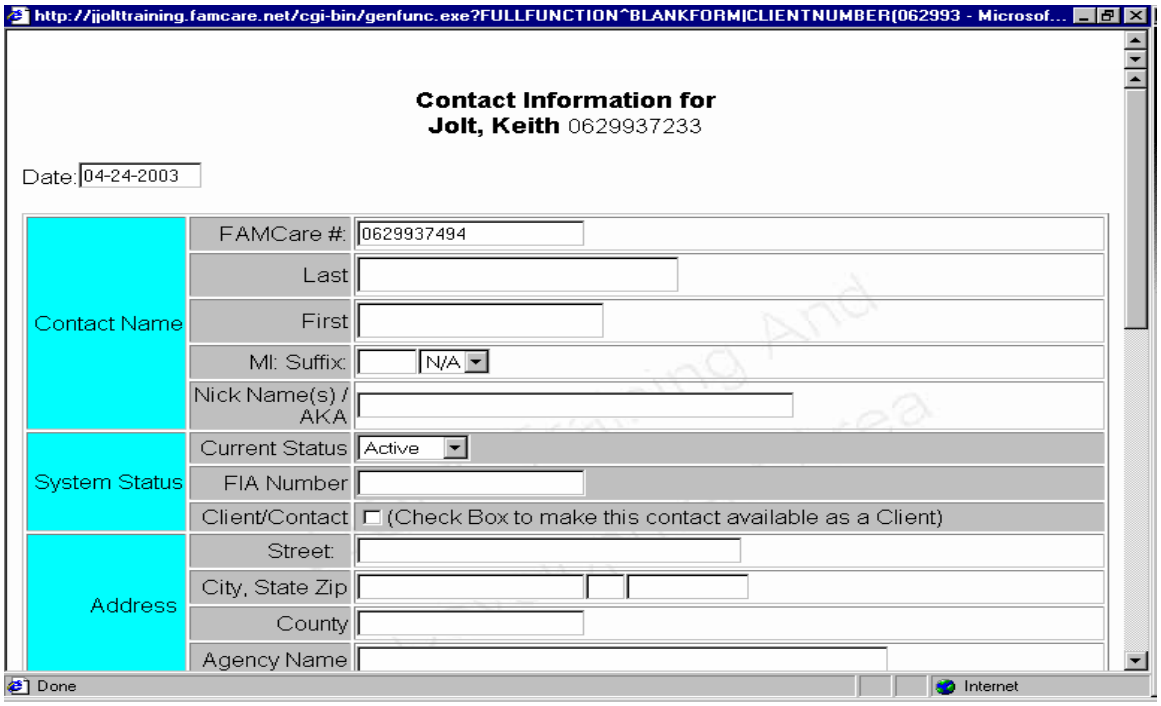
1. "click here to add"



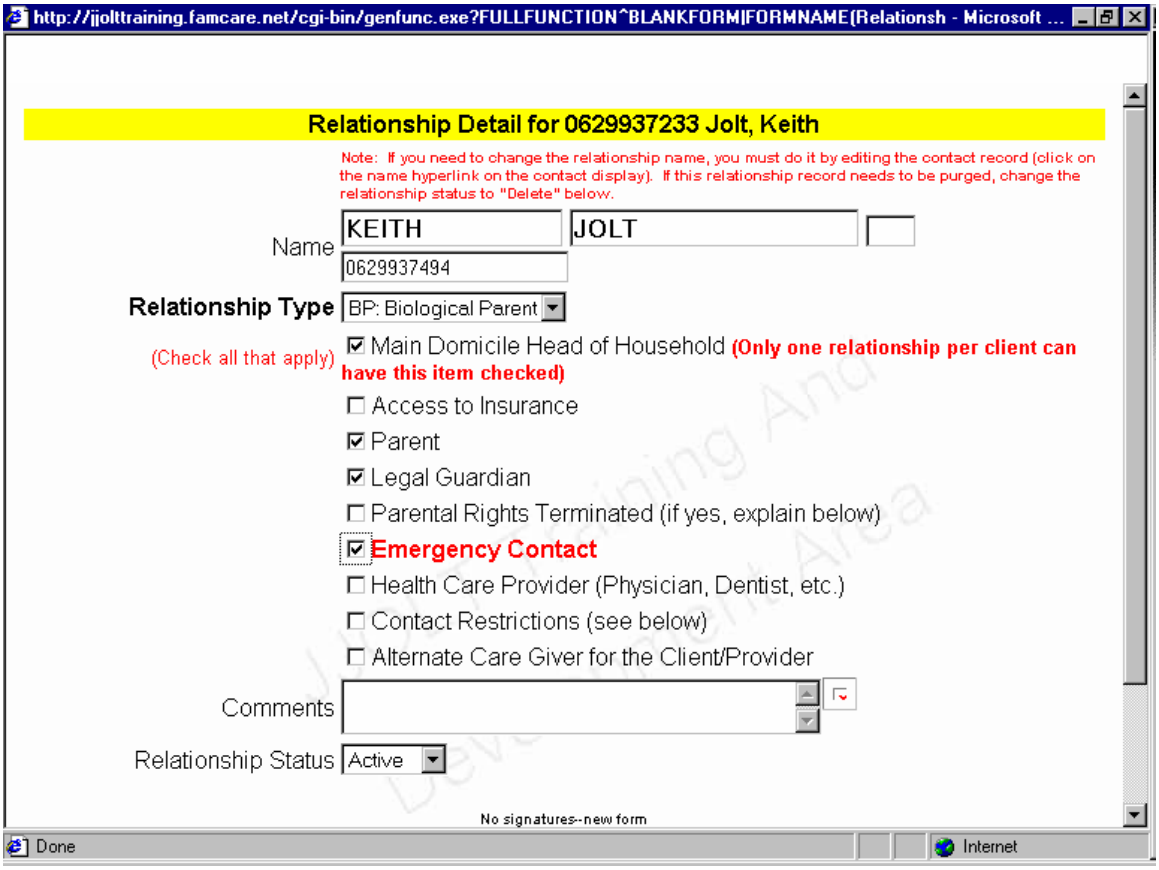
2. This will bring up a Search Screen, as seen on the next page. Again, you must search for this contact, as they may already be in the system as a contact for another youth. Type in the contacts' last name (also using a wildcard Ja*). If they are in the system you can just click on their name and add the new information. If not you must click on the "Add a new contact to the master record"



The purpose of this search is to avoid duplicate entry for contacts that may already be in the system. Add all known contact information (name, DOB, Address, phone, etc.) Sign and save this form.

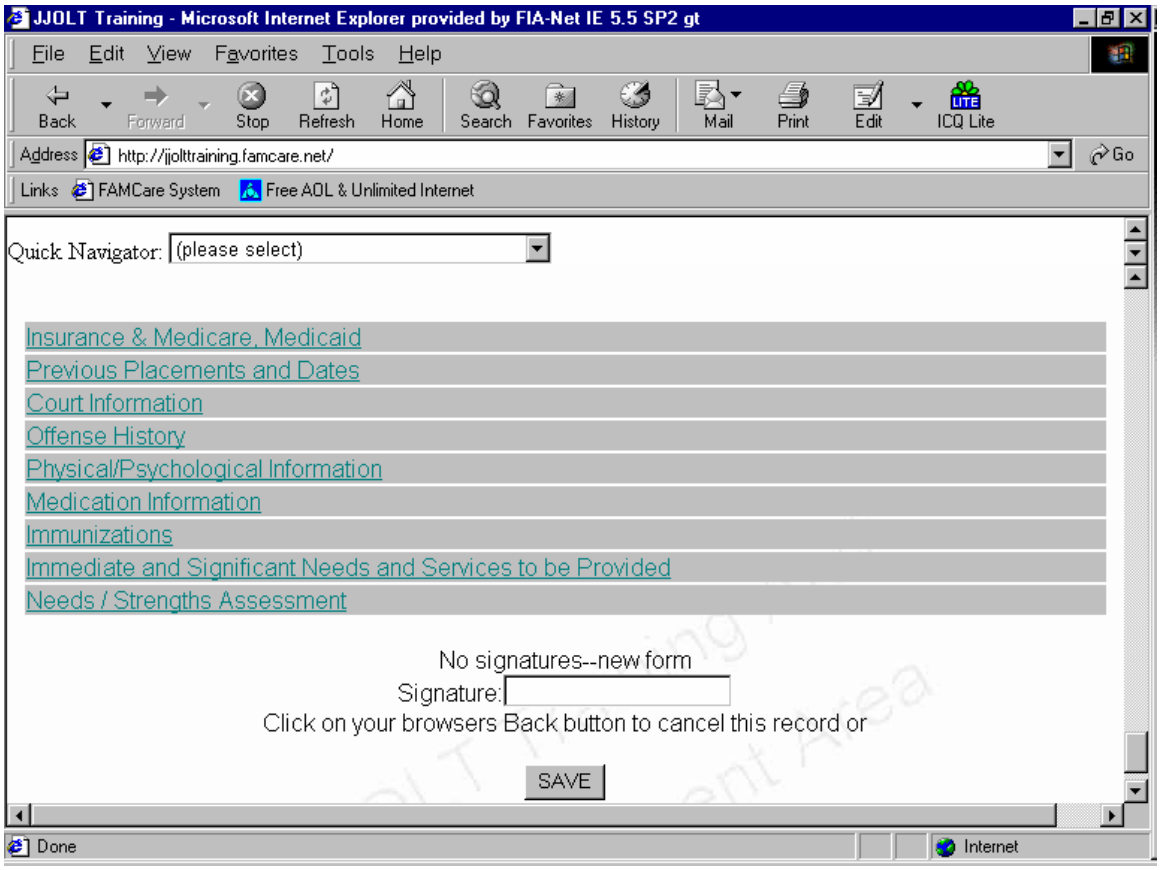


1. You then must add Relationship details (**Please see screen on next page**). . It will only show up on the intake record as a Parent or Guardian if you have checked those boxes. Also, if you check Main Domicile, you will change the youth's main record to the parents' address. Also, it will only show up as Contact Restrictions if you check the appropriate box.
2. Sign the form, Save it and then you will get the confirmation screen. Scroll down until you see the Click here to refresh summary, and you will then return to your main Intake record, and the information added should be there.



Continue to Scroll through the Intake Record adding all information available. Case manager is the JJS worker. Committing County and Referring County, Committing Offense, Religion etc.

At the bottom of the screen you will see links for Offense History, Medical /Psychological Information, medication Information etc. Add all information that you have available. If you do not have it, that is OK, only add what you know.



Previous Placements and Dates
This part of the form is automatically updated when the Intake Unit admits a youth to a program; you should not have to add any information to this section. This will also pre-fill in the appropriate areas of your Treatment Plans.

Offense History
This form is self-descriptive, allowing for input of the Client's offense history. For each Offense, and Adjudication date and status must be filled in.

Physical/Psychological Information
This form is self-descriptive, allowing for input of the Client's current physician and psychiatrist, the date of the last physical exam, and notes. A link is also provided to the Medications and Immunizations forms.

Medication
The "Medication" form is used to document all medications prescribed for the client, including prescription number, pharmacy name, referring physician, dosage and any special instructions. Each type of medication requires a separate record, which can also be edited. This section is required for all agencies to keep updated. Any time a youth has a medication change, the Group Leader, Medical staff, or whoever is assigned must go in and complete this information. If a client refuses to take their medication, this can be addressed in an Incident Report, which will link itself to the Medical Section in JJIS

Immunizations
The "Immunizations" form is used to document any immunizations that the Client has received and also to input those that are necessary but not yet received (or expired). You may also be able to scan in an immunization record so it is always available.

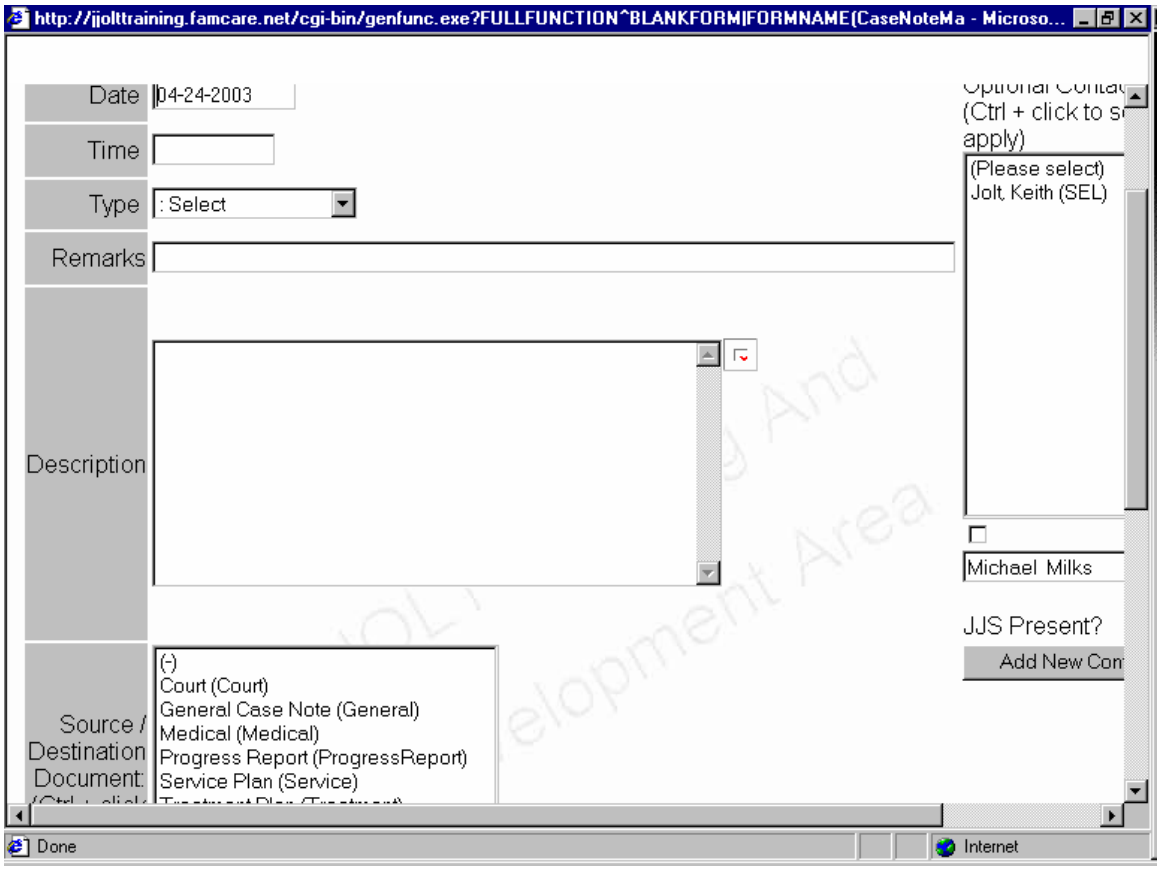
Immediate and Significant Needs and Services to be Provided
This form consists of text boxes for special notes regarding the physical needs of the Client and/or emotional needs of the Client and parent. This is excellent for intake staff and would be helpful if staff kept this up to date.

Saving Information
At the end of your Intake Summary, one last time you must sign and save your complete form. The computer does not know that you are actively working on a record unless you are hitting any save button at least hourly. If you have not done this, you may get kicked out of the system and not even know it, thus none of your information will be recorded. **Make sure you are saving regularly!**

CONTACTS/CASENOTES

Some people prefer to create Case Notes/Contacts as they occur individually, and some prefer to jot them down on paper then add them all at once while writing a Treatment or Service Plan. Either way, the data entry is the same.

Click on the ***Add Case notes*** anywhere from within 1A, from 1I, from 8B, or while in a treatment plan.



1. You will type in the date the case note occurred, time is optional.
2. Select the type of contact from the drop down box.
3. Select the contact person (you can select multiple people by hitting your control button and your mouse at the same time to select or deselect multiple people). If your contact is not listed, you will click on ***Add Contact***, and refer back to Parent Guardian info section to create a contact and relationship. Also you can check whether the JJS was a part of this case note by checking that box.

4. Remarks is a brief description of the case note that will appear on your Plans, Description is a more in depth text of what occurred. Someone would have to open this case note up directly to get this description.

5. Select where you want this case note to populate i.e. Treatment Plan, Service Plan (for JJS workers only) Medical etc… Most of you will always select Treatment Plans.

6. There is a Private box, these are notes that only you will have access to. No one else will even see that they were created. This is generally used for the Clinical Psychiatric staff, but if you use this selection these will not show up on Treatment Plans.

7. Your choice then will be to either **Quick Save**, which will then allow you to add another case note and so on until you have added all that you wish up to 20, or **Save/Close** which will save that case note and return you to the main form you were working on. (You can also cancel the case note and return to your form etc…) The schedule button is not a functional part of the case note section at this time so you do not need to worry about this, at this time.

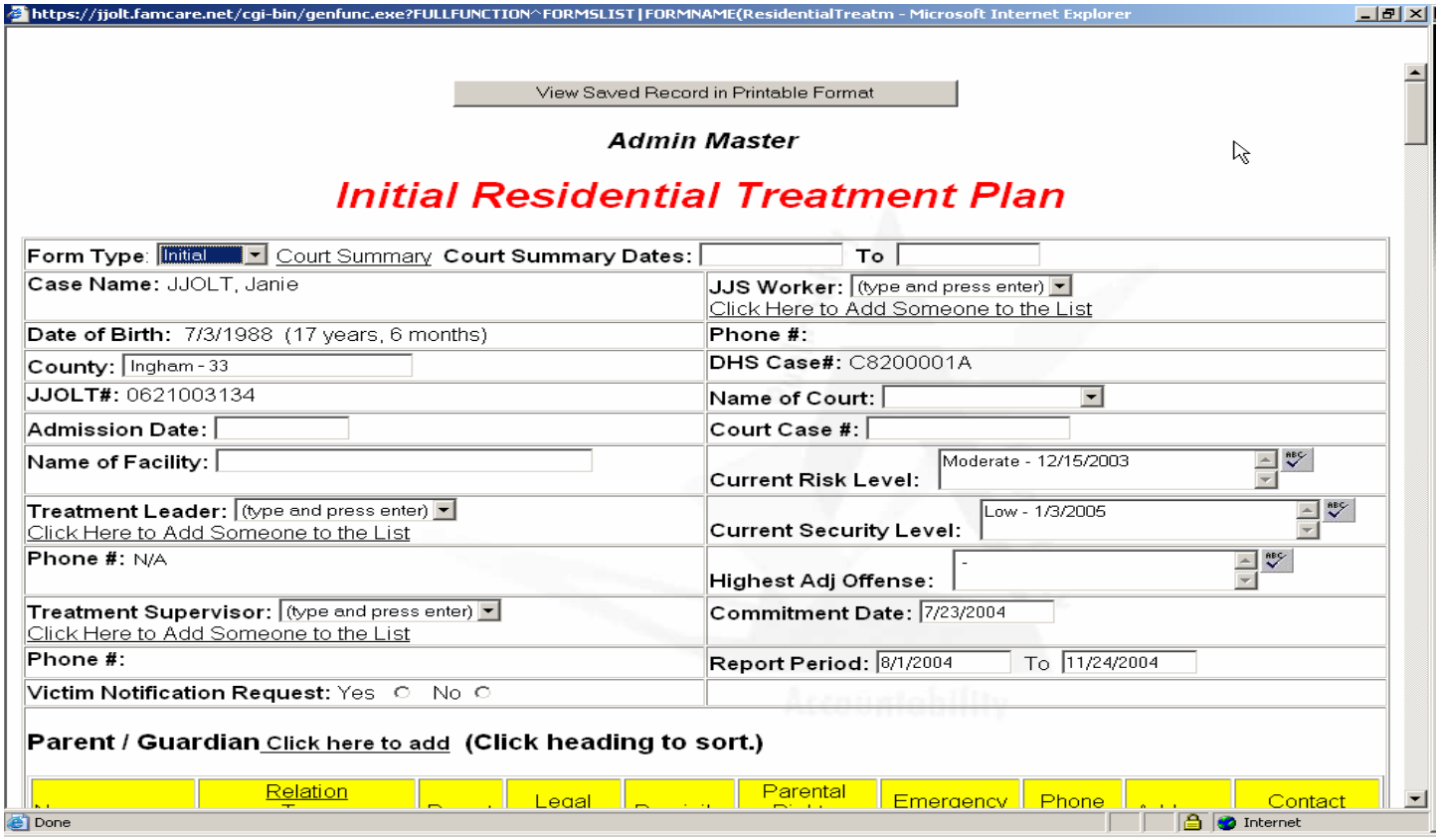
8. Your case notes that occur within your Treatment or Service Plan for JJS workers reporting periods will automatically show up no matter where they were created from.

Once the "Intake Record" has been completed, the Client's assessments are entered next. The Treatment Plans "Forms Menu"(3C) contains the assessment forms that are available for various purposes.

Residential Treatment Plan

All of the prior input has been related to documenting the history of a Client and providing a thorough analysis of the Client's current condition and environment. The Initial Service Plan has set goals for the Client and documented acceptance of these goals. The Residential Treatment Plans provide the logistical details for the accomplishment of these goals and also provides the form for follow-up. A case management section allows for updating based on current events as well as subsequent meetings with the Client (called a Participant on this form), as well as the other related parties (parents, CMO, provider, etc.).

The Treatment Plans contain links to several other forms for updating. These include "Contacts," "Offense/Court Information," "Provider Placements," Clicking on any of these links produces a screen, which can be updated or just referred to. **Please note that the Strength and Needs and Risk Reassessment are separate forms, they must be opened and saved individually, Please refer to 3G and 3I on your forms menu.**

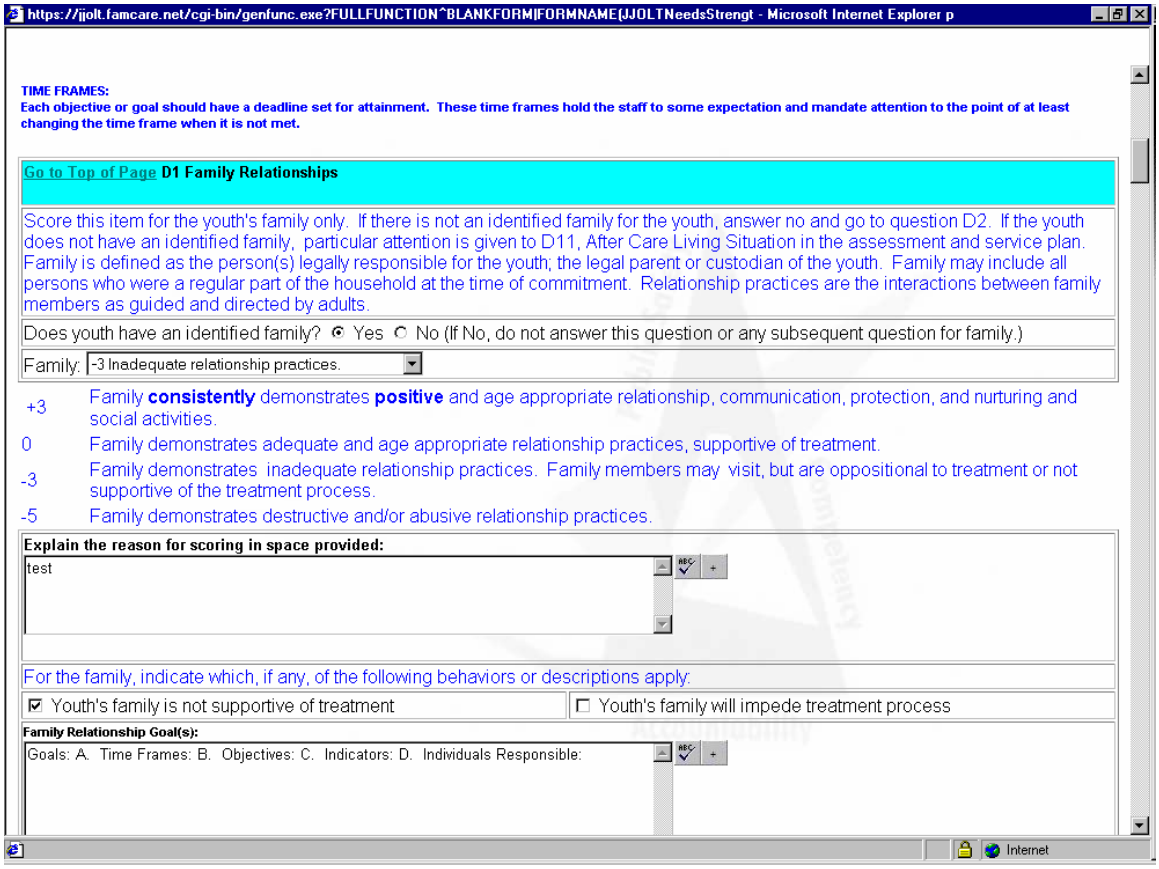


To begin, when you first start a JJIS treatment plan for a youth, even if you are starting with an Updated Treatment plan, (for a youth that has been in your program for some time) you will "Create a New Form". When this opens you will be requested to "select a form". Select the appropriate choice **then hit your TAB key**. This will set your form. Check your admission dates. If you are starting with an Initial Treatment Plan, your Admission Date and Report Start Date should be the same. Your report periods and months in care will automatically calculate by Tabbing through form. You will need to select your Judge as sometimes these changes frequently and we did not want these to be set in stone. Now this should look just like the current Word documents we use at FIA. Add information to your treatment plan as you normally would.

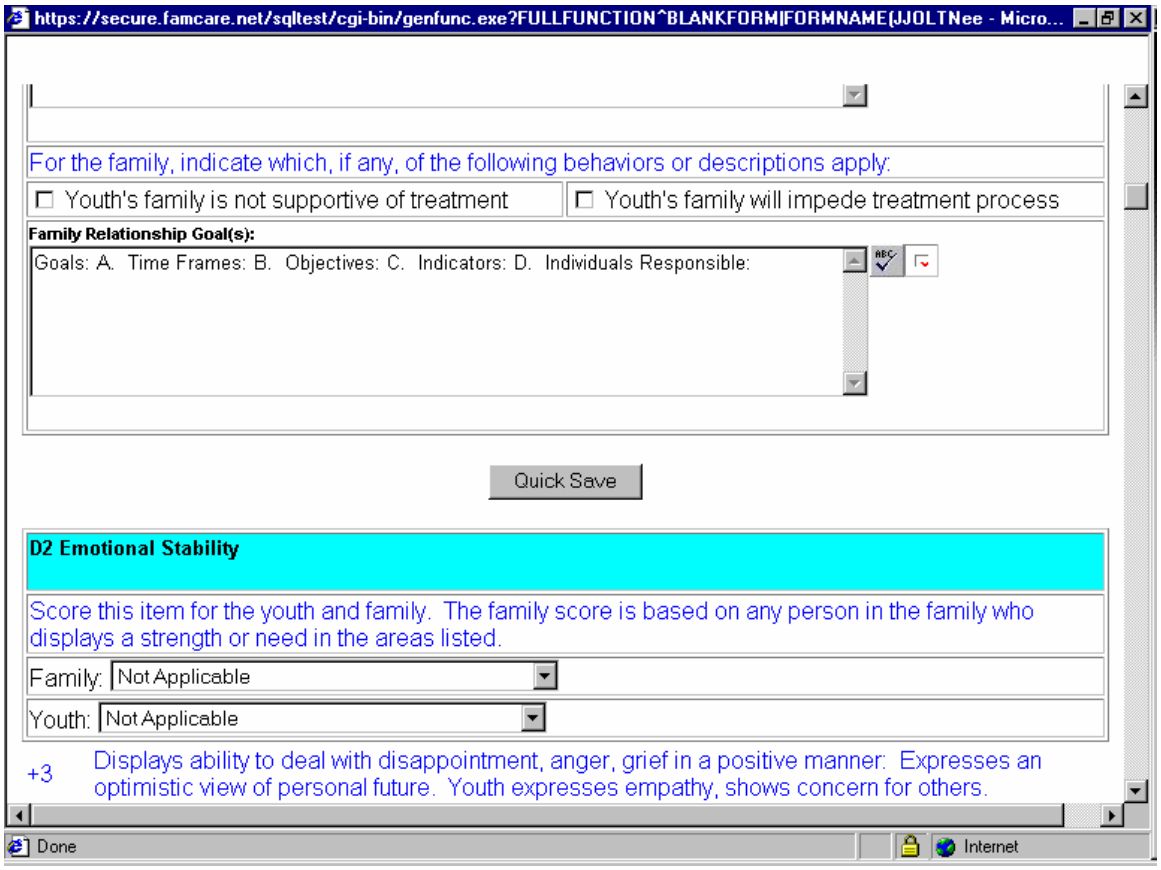
Strengths/Needs Assessments

One of the key forms in this section is the "Strengths/Needs Assessment" form, which is used to develop the Initial and Updated Service Plans. This screen will also be revisited to update the Residential Treatment plans when there are significant changes during the report period or develop a Release plan. Click on this line item (3G) to select it from the menu to create a stand-alone document. This will take you to the next screen to create a new form or to copy an existing form.

Selecting any option will produce the "Needs and Strengths Assessment" form, as shown below. It looks just like our current Word document.



Please also see next page



The easiest way to input your goal information is to:

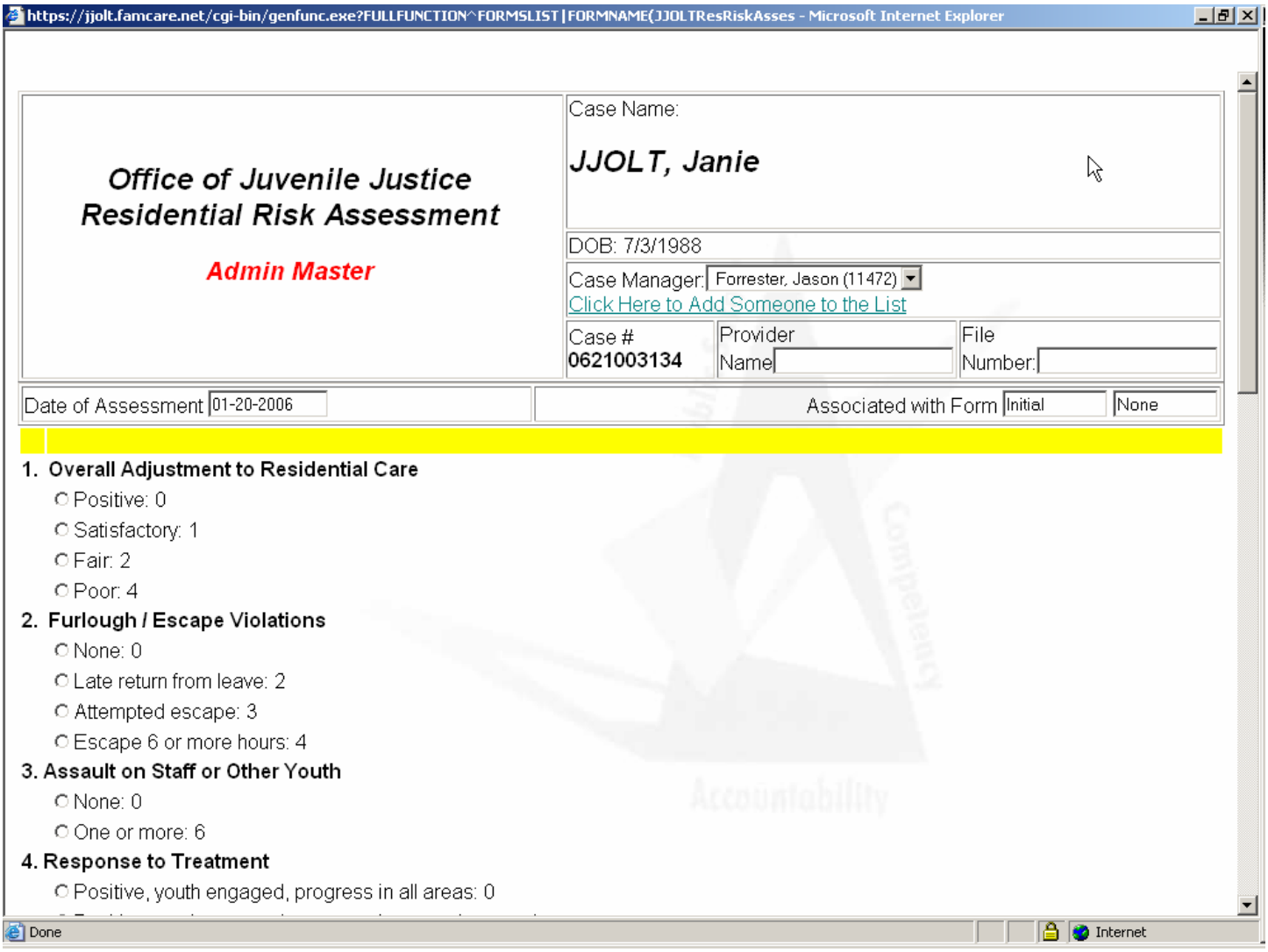
4. Place your cursor behind the word 'Goals'. Add your Goal statement then hit enter. You will start your next line.
5. Place you cursor behind the words "A. Time Frames" and type in your time frame (i.e. 6 to 12 months) then hit enter.
6. Place your cursor behind the words "B. Objectives" and type in your objectives and hit enter. Do this until you have completed "D. Individuals Responsible" and Your Goals along with A<B<C<D should all be in a neat format.

You can also cut and paste form a Word document if you prefer. The document does have Spell Check now and each section that has a text box should have the spell check in the margin area. It does not spell check your entire document at once; however, you must check each individual text section.

Once the record has been saved, the "Save Confirmation" screen appears. This has the same functionality as the "Save Confirmation" screen for the "Intake Record" – a printout can be produced or the user can go directly back to the "Residential Treatment Plan" to make further modifications to the Client's record.

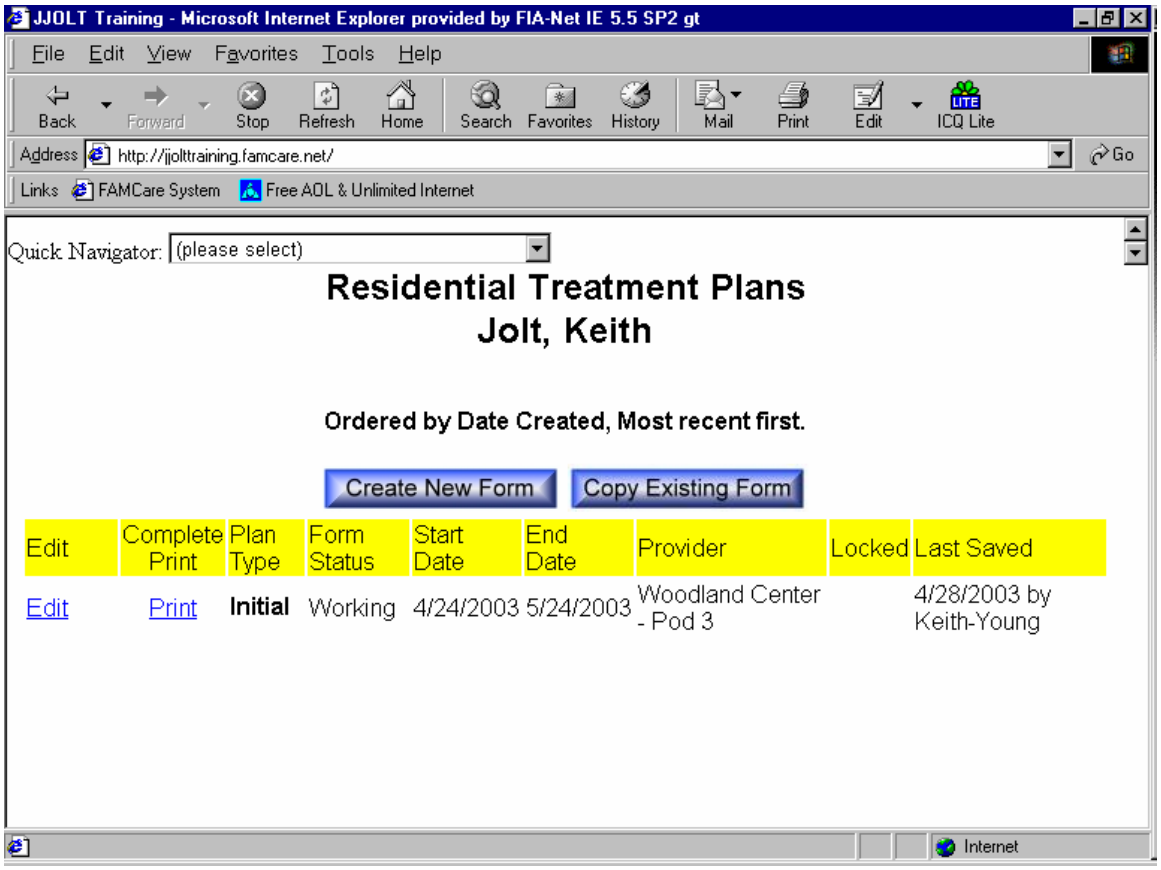
Residential Risk Assessment

The "Juvenile Residential Risk Assessment form (3H) is created by the JJS and utilized by JJAU and Treatment Programs to determine a Client's initial risk and security classification. Again, this form looks just like our current word document.
NOTE: As with the other risk forms in this section, the risk scores will be automatically calculated each time the information is input and updated. However, in this case, this is a one time only form. The Highest Adjudicated Offense will then automatically pre-fill the security level, and then you can scroll down and fill in an override if necessary.

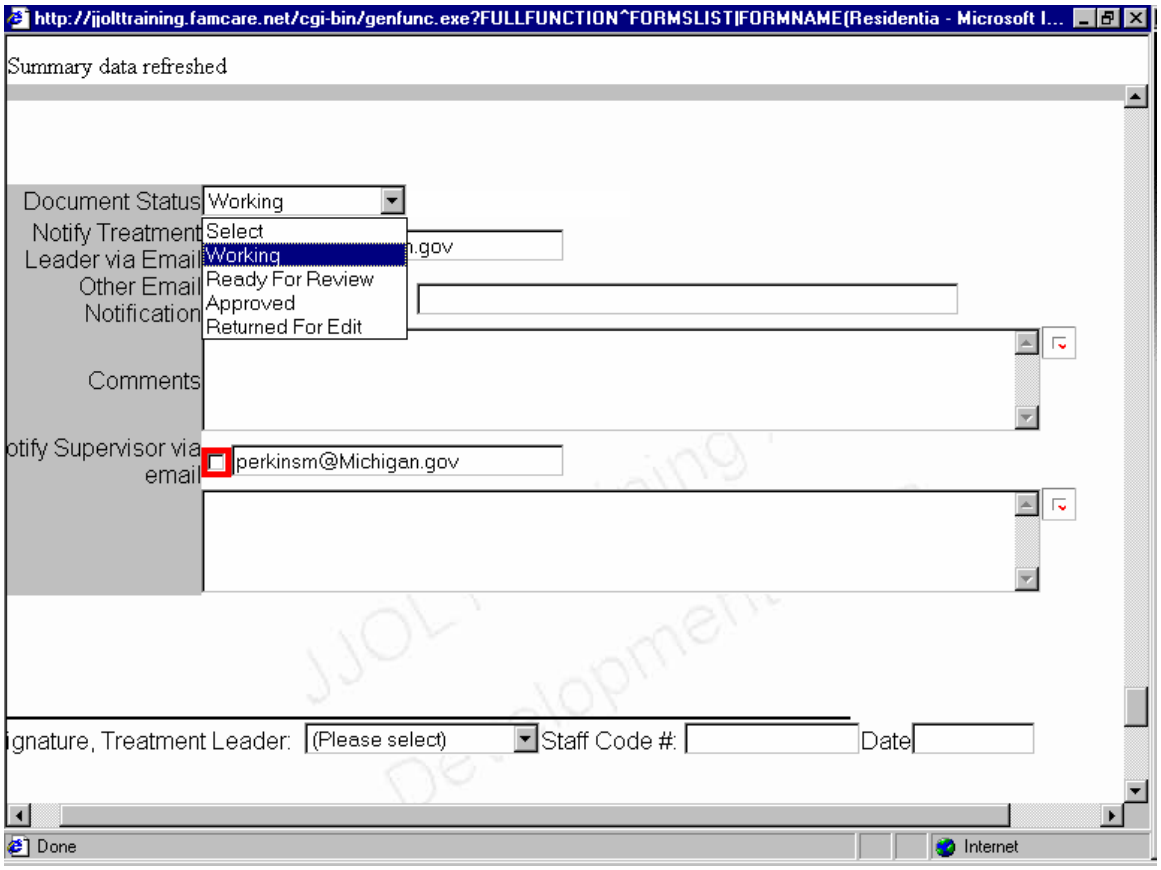


.

As long as you are working on a plan, every time you want to open it up, click on the ***Edit*** button next to the plan you are working on.



When you are finished, if you have an appointment, or whenever you need to leave working on your Treatment Plan, at the end of the document you will see a box to select either “Working”, “Ready for Review”, “Approved” or “Return for Edit”. As a Treatment Leader you will select either working or ready for Review, a Supervisor will select either approved or Return for Edit. Once a Supervisor puts in their Signature (password), and clicks on “Approved” there will be no more edits that can be made! At the time that a Supervisor electronically signs the report, the bold face **Draft Copy Not Approved For Court Use** will disappear from the top of the Treatment Plan.



When it has been finished and approved etc… for your next quarterly report or release report you would then click on the "Copy Existing Form". It will bring up all your old data from your previous report but now you can make changes to it…Keep repeating until youth is discharged.

Court Report To prepare a Court Report from a completed Updated Treatment Plan, go to the top of the first page of the Updated Treatment Plan and click " Court Summary. " The system will automatically prepare a one or two page Court Summary using the information already entered into that section of the report.

Spell Check To prepare your computer for spell check you must go to the task bar in the Internet and click on Tools, click on Internet Options, click on Security, click on Internet, click on Custom Levels, click on the Radial button that says" Initialize and script Active X to make safe," click OK, click Yes when it asks Are You Sure? This will never have to be done again.

Department of Human Services	Bureau of Juvenile Justice Juvenile Justice Information System (JJIS) OPERATIONS HANDBOOK

CHAPTER:	Adding Identifying Numbers (revised 1/10/2006)		
		Page	1 of 5

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General Overview

The Passport table is a central repository that maintains a list off all of the identifying numbers for a given youth. Such numbers include: Drivers License Number, DHS Number, etc.

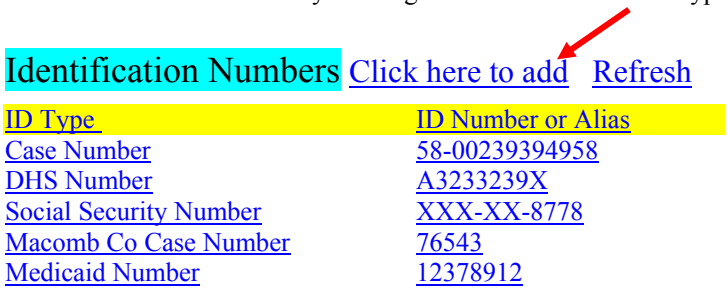
JJIS currently houses several id numbers in the main Client record. These are now moving to the Passport Table. Included are the, DHS Number and JIS Number.

Effective January 1, 2006, DHS cannot allow access to any document that contains the full social security number of youth or staff. Any youth social security card and JJIS documents, including the Youth Face Sheet, that contains that information must be removed (or in the alternative, replaced with a copy those documents with the social security number deleted) before any outside party (such as MPAS) has access to a youth's file. Any staff identification cards that contain the full social security number must also be replaced. **** FOR THE USERS **** JJIS will be pushing a change in how the SSN number is shown the first week of January. You'll notice that you put in the entire number, however only the last 4 numbers will appear on JJIS forms. The Social Security numbers will now be entered on the Client Intake Summary – Main menu 1-A. The numbers will still appear on the appropriate forms as they do now. Other numbers will be entered on the same screen.

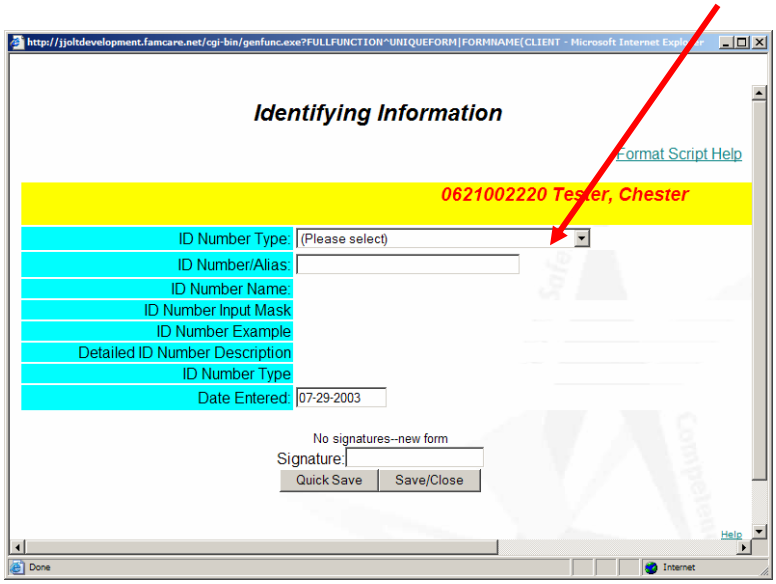
Each number has an “input mask” which dictates the form and structure of the number. For example, when you enter a DHS Number, it will only allow an alpha letter followed by a 7 digit numeric entry and followed by another alpha letter. Many other client specific numbers can be entered through this same function.

Client Passport Summation among others on the Client Screen

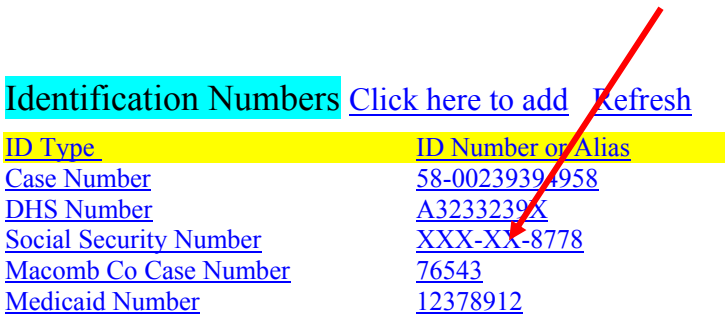
1. Add new Number by clicking the “Click here to add” hyperlink



2. Select the appropriate number to add from the following window and enter in the number in the ID Number/Alias Field and click save



3. The new number can be edited in a similar fashion by clicking on the value to edit



Department of Human Services

Juvenile Justice On-line Technology

JJIS

Training Manual

Incident Report Users Manual

6 March 2006

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1.1 PURPOSE.

The incident report is a written record that documents historical information and a source document that supplies data to the database within the Juvenile Justice Information System (JJIS). BJJ residential policy requires that staff involved in an incident complete an incident report prior to the end of their shift. The staff routes the paper incident report to the on site supervisor who reviews the report for completeness, signs the report, and then routes the report to a facility locked box for centralized review and follow up. The on site supervisor also routes other copies as needed to relevant facility offices (for example, medical, maintenance, personnel, etc.).

When multiple staff are involved, each staff writes an incident report. The on-site supervisor or other facility assigned staff collates all paper incident reports for each incident and then consolidates the information into a Computerized Version (CV) of the incident documented in the JJIS. Policy requires that this consolidation occurs within 24 hours of the incident. The consolidation from paper to JJIS is validated by an uninvolved third party at periodic intervals as part of BJJ Internal Controls procedures.

1.2 INSTRUCTIONS FOR COMPLETING THE BJJ PAPER INCIDENT REPORT.

1.2.1 Administrative Requirements.

1. Print legibly in blue or black ink when completing the incident report. Do not use correction fluid, tape, or scribble over entries to correct errors.
2. Document the events as they are observed or experienced. Do not guess about what might have happened or attempt to predict what may happen in the future.
3. Use language familiar to the general public. Avoid using jargon or slang. If using an abbreviation in the narrative, write out the abbreviation the first time it is used. For example, use Life Safety Unit (LSU) instead of LSU.
4. If a mistake is made, either start over or line through and initial the content of the incident report that is in error.
5. Use full names (first and last) of youth and staff when listing those involved. When referring to youth and staff in the narrative section, using last names (Staff Jones, Youth Winslow) is acceptable as long as names remain clear.
6. If there is more than one item, be specific. For example, instead of “Youth grabbed and twisted my leg..” “Youth grabbed and twisted my left leg.”
7. When describing actions associated with assault, describe the nature of physical conflict in detail. For example, “...Youth Reynolds punched Youth Smith in the stomach who then grabbed Reynolds dragging him onto the floor in the dayroom. Smith then crawled on top of Reynolds and punched Reynolds in the face until staff Adams and Carter pulled Smith away ...”
8. Normally, either a youth on youth assault or a fight occurs, but not both. Code one or the other to avoid duplicating the same event.

9. When documenting medication issues, include the medication name, dose, and when the dose was due. For example: Youth John Doe refused his Noon 50mg dose of Ritalin.
10. Ensure that for each case where the youth is restrained, that restraint start and stop dates and times are included. This may require initially submitting the paper incident report reflecting the starting date and time of the restraint and then documenting the ending date/time of the restraint as soon as possible, but at a later time. Separate times are required for each type of restraint (Physical and mechanical).
11. Ensure that for each case of isolation and/or confinement, that entries for each of the youth who is confined and isolated along with the start and stop dates and times are included. This may require initially submitting the paper incident report reflecting the start of confinement/isolation and then documenting the end of the confinement/isolation as soon as possible. Separate times are required if the isolation type or reason changes.
12. When completing the incident report, **check all applicable characteristic checkboxes**. The Noncompliant in Program checkbox should be checked as appropriate. Note that use of these boxes may trigger the need to complete restraint, confinement/isolation, or medical data.
13. For incidents involving restraint, assault (including fights), isolation/confinement, suicidal behavior, ensure that any injuries are documented.
14. For incidents that include injuries, include all applicable information including date and time that medical treatment was provided, the name and position of the treatment provider, and the type of treatment provided.

15. Any staff who participates in an incident or supervises youth who are involved in an incident must complete an incident report prior to the end of the shift and route the incident report to the supervisor.

1.2.2 Step Sequence for Completing the Paper Incident Report.

Complete the paper incident report before the end of the shift. Use the step sequence as a guide. Different step sequences based on the nature of the incident, facility, and personal experience with incident reports are acceptable.

1. Complete base information (Who, Where, When)
    a. Individual (Last Name, First Name)
    b. Check the Youth, Staff, Other checkbox
    c. Facility Name
    d. Location in facility where incident occurred
    e. Incident Date and Time
    f. Names of youth, staff, and others that are involved
2. Write the incident report details
3. Code the main incident report characteristics
4. Code the youth specific characteristics
    a. Restraint
    b. Isolation/Confinement or Seclusion
    c. Due Process
    d. Interventions
    e. Injury
    f. Seen by Medical/Medical treatment
5. Review, sign, date, and submit to on-site supervisor for approval
6. Update conditional data (ending isolation/confinement, removing restraints)
7. Edit data-add, delete, or modify information based on understanding/knowledge/new facts

Note: Because the original incident report author and a supervisor have signed for the content in the incident report, any additional information should be written on the back of the incident report form. If there is a major change to the incident report, either have the original author and supervisor correct the report or complete a new incident report form with an explanation to the original incident report form. Staple together both forms.

Note: Because the paper incident report was designed to fit on one page, cases where more than one youth or staff are involved in special characteristics will involve using additional pages and checking the narrative continued checkbox on the paper incident report form.

1.2.3. Paper Incident Report Field Grid

Entry Name	Entry Required	Remarks
Incident Date	Date of incident	
Time	Time of incident	
Individual	Main subject of incident	Normally the person who is the cause or who makes the incident occur; usually a youth
Youth/Staff/Other	Check the applicable box	For the individual above
Facility	Facility Name	Name of licensed facility, for WJ Maxey Boys Training School, use Woodland East or Woodland West
Location	Where the incident occurred	Within the facility (e.g, Living Unit, Pod, Wing/Hall, Cottage Youth room, Class room, Gym, etc.)

Incident Details	Narrative account including situation and result of incident; include detail for injuries and medical attention	Information observed or experienced about what happened.
Narrative continued	Check if more than one paper form is needed	Denotes continuity onto another incident report form
Interventions Applied	Check applicable checkbox for each youth as appropriate	Specific to each youth listed in the incident; for some youth, may be blank
Due Process Hearing Requested by Supervisor	Check if Due Process Hearing is requested	
Code Violation	Enter appropriate code for offenses violated	Alphanumeric codes linked to offenses at the facility
Characteristic Checkboxes	Check each and every one that is appropriate	Check all that occur during the incident; should match content in the narrative. Ensure compliance with definitions in this manual.
Physical Restraint Checkbox	Check if a physical restraint occurs (one for each physical restraint in the incident)	Each youth physically restrained in the incident requires a sheet that has this checkbox checked
Physical Restraint Supervisor Notified Initials/Time	Fill out if a physical restraint occurs (one for each physical restraint in the incident)	Initialed by person notifying supervisor and time is the time when the supervisor is notified.
Mechanical Restraint Checkbox	Fill out if a mechanical restraint occurs (one for each mechanical restraint in the incident)	Each youth mechanically restrained in the incident requires a sheet that has this checkbox checked; can be checked along with physical restraint checkbox (as appropriate)
Mechanical Restraint Supervisor Notified Initials/Time	Fill out if a mechanical restraint occurs (one for each mechanical restraint in the incident)	Initialed by person notifying supervisor and time for time supervisor is notified.
Transport/Behavior Checkbox	If at Woodland Center, follow facility procedure, if elsewhere fill in for behavior	Uses of mechanical restraint for transport do not require an IR; transport=off campus
Hands/feet/mechanical restraint type	Complete for each youth who is mechanically restrained as appropriate	Additional sheets may be required.
Confinement used	Check the checkbox if the youth is isolated or confined in his/her own room or an isolation room	
Confinement used/Supervisor Notified (Initials/Time)	Fill out if the confinement used checkbox is checked	
Confinement reason	Check one and only one of the checkboxes	If reason changes, document a separate confinement with its own start and end date/time
Own Room/Isolation Room	Check the checkbox as appropriate; if room changes from one to other, add a continuation sheet to IR to document both	East Williams at Adrian and Life Safety Unit Pod 3 at Woodland Center are isolation rooms. If Own Room/Isolation Room changes, document a separate confinement with its

		own Room Type, Reason and start and end date/time
Time IN	Time entering the room	Should match facility logging form/log
Date IN	Date entering the room	Should match facility logging form/log. Must be same or after Date of Incident
Time OUT	Time leaving the room to return to program or going to another type of room confinement	Should match facility logging form/log.
Date OUT	Date leaving the room to return to program or going to another type of room confinement	Should match facility logging form/log. Must be same or after Date of Incident and Date IN
Injuries to Individual	Check one of the six checkboxes	If application of restraint is checked, ensure that type of restraint (physical or mechanical is coded on the incident report. If victim of assault is checked, ensure that assault is coded on the incident report
Medical Attention Required	Check if medical attention required	If this block is checked, ensure narrative describes when treatment was provided, what type of treatment was provided, and names of any medical and/or mental health personnel involved.
Injuries to Others (Last Name, First)	Fill in name (May be youth, staff, or other (e.g. volunteer)	This is for injuries to those other than the individual above.
Other identifier checkbox	For injuries to those other than the individual in the individual field at the top of the incident report; check the checkbox if youth, staff, or other.	If injuries occur to more than the individual and one other person, add additional forms to document the injuries in this block
Nature of injury	Check one of the six applicable checkboxes	If application of restraint is checked, ensure that type of restraint (physical or mechanical is coded on the incident report. If victim of assault is checked, ensure that assault is coded on the incident report
Medical Attention Required	Check if medical attention required	If this block is checked, ensure that the narrative describes when (date/time) treatment was provided, what type of treatment was provided, and names of any medical and/or mental health personnel involved.
Reporting Staff Signature	Signature of person writing the incident report	
Reporting Staff Typed or Printed Name	Name of person writing the incident report.	

Date of Report	Date incident report was made.	
Supervisor Signature	Signature of on-site supervisor reviewing the incident report	On-site supervisor
Typed or Printed Name	Name of on-site supervisor	
Date of Review	Date that on-site supervisor is reviewing the incident report	

1.2.4. Numbering Paper Incident Reports.

1. Write a unique identification number in the upper left hand corner of each paper incident report form that is used as follows:

A two digit facility code
A two digit code for the month of the year (01=January, 12=December)
A two digit code for the day of the month (01-31)
A two digit code for the sequential number of incident report form used with that date (01-99)

Note: The sequential number code resets with each new date. That is, if there are five paper forms with date of incident as 10 March, their sequence numbers would be 01, 02, 03, 04, 05. 11 March incident reports would start with 01, 02, 03, etc.

Facility Codes are as follows:

Facility	Facility Code Number
Adrian	11
Bay Pines	12
Nokomis	13
Sequoyah	14
Shawono	15
Woodland East	16
Woodland West	17
Academy Hall	18
Arbor Heights	19
Flint House	20
Parmenter House	21
Pine Lodge	22

Example: Incident Report 13051204 is a Nokomis incident report that occurred on 12 May and was the fourth paper incident report form written for a 12 May incident.

1.2.5. Consolidating Paper Incident Reports Into the Computerized Version (CV) in the JJIS.

During consolidation, multiple paper incident reports are reviewed and merged into an accurate unified summary or Computerized Version (CV) of the incident in the JJIS. All paper incident reports are consolidated, whether one paper incident report or several apply to the incident. If only one paper incident report exists, then consolidation consists of reentering data from the paper version into the JJIS. Follow consolidation rules as follows:

Note: Paper incident reports are considered source documents that feed the CV. Consolidators should not add, delete, edit, or otherwise change information in the paper incident report. Errors in paper incident reports should be resolved prior to entry into the CV.

Note: In several cases, consolidation involves forming a union of all common information from several paper versions and reflecting these in the CV. Where the term union is used for these rules, union is the sum of the items in each group with common items listed only once). . (That is, if one version has J. Smith and T. Jones and one version has J. Smith, T. Jones, and E. Fisher, the CEV should include J. Smith, T. Jones, and E. Fisher).

Note: Ideally, all paper versions of the incident report should be nearly identical. If the versions are sufficiently different to make consolidation difficult, the reports should be checked to see if they are from different incidents. If this does not help, contact the supervisor who signed the reports to attempt to achieve clarity.

Note: Do not attempt to correct, edit, or fill in missing blanks on paper incident reports unless you wrote the report or were the supervisor signing the report.

1. Earliest time/date rule. For cases where the time or date of incident are not the same on different paper versions, check to ensure that each paper incident report in fact belongs to the incident in question, then select the earliest time/date.

2. Youth involved union rule. For cases where there are more than one incident report and listed youth involved are not the same, use the union of all youth in each paper incident report form. (For example, if IR 1 has Youth A and B, IR 2 has Youth A,B,C, and IR 3 has Youth B and D, the CV should reflect Youth A,B, C and D).

3. Staff involved union rule. For the names of staff involved, use the union of all staff involved in each paper incident report version. Unless an incident occurred for one staff by themselves or for a youth who was not supervised by staff, there should be at least one youth and one staff listed.

4. Selected best narrative rule. For the incident report narrative, use a word-by-word transcription of the incident report details from any one paper IR version. Place the date/time of the paper IR, and the name of the staff authoring the IR in the narrative to link the transcribed narrative with its paper version. Do not attempt to use narrative from multiple IR or create new narrative in the JJIS narrative.

5. Characteristic coding union rule. For cases where the coding of characteristics from the main page of the incident report is different, use the union of all the codes on the paper incident report forms. If a coded characteristic checkbox is not checked on at least one paper incident report form, it should not be checked on the CV in JJIS.

Note: The incident report details and coding when viewed as a whole provide a true and accurate description of the incident. However, when written properly, the narrative should be sufficiently detailed and complete to support coding of relevant characteristics.

Note: Differences and inconsistencies should be detected and resolved by the author and supervisor who writes and approves the paper incident report. Persons entering the CV in the JJIS are performing collating and consolidating functions and should not add or delete content from the incident report details or characteristic coding.

Note: For youth in isolation or confinement, the duration of isolation or confinement may extend beyond the period where incident reports are consolidated. Facilities should establish procedures for updating the original paper incident reports and adding this information in the CV as soon as it is known. The JJOLT Residential Report for Isolation/Confinements can be run periodically to identify these occurrences.

6. Longest Duration Rule. In cases where the incident report forms have different durations of restraint or isolation/confinement for a youth, consult the applicable restraint or isolation/confinement log for the proper values. If a conflict remains, use the duration that is longest.

7. Restraint union rule. In cases where paper incident report forms contain differing information regarding restraints, use the union of all restraints.

8. Injury union rule. In cases where paper incident report forms contain differing information regarding injuries, use the union of all injuries.

1.3 INSTRUCTIONS FOR COMPLETING THE JJIS INCIDENT REPORT.

Note: If more than one youth escape at one time, enter a JJIS Incident Report for each escaping youth to parallel the practices for Escape Notification and Escape Reporting. This is a special exception to normal consolidation practice.

For a Youth on Youth Fight, the fight is considered one incident with two or more youth involved. One fight may produce several paper incident reports but should produce only one JJIS Incident Report (CV). For fights, selection of the primary youth field in the JJOLT incident report is at staff discretion, does not imply culpability or causality, and should not be used as a basis for imposing discipline.

If a JJIS Incident Report is entered in error, contact the JJIS Help Desk for assistance in deleting the incident report.

1.3.1 Procedures for Entry of Incident Reports in the JJIS.

Group the completed paper incident reports together by incident.
Write the number of the paper incident report on each of the paper incident report forms; each form should have its own unique number.
Enter the JJIS to create incident ieports from the Client Select Menu.
Using the Quick Navigator drop down menu, select **Select Client** using the pick arrow. Scroll down to and select **Current Incident Report**.
On the screen that appears, select the facility name from the Drop Down Menu, then click on the teal hyperllink **Click here to add New Incident Report.** The incident ieport front page will appear.
Enter the number of paper incident reports written on the incident (for example, 1, 2, 3, etc.) in the appropriate field. The default value is one.
Enter the identification number for each of the paper incident reports separating each entry with a comma. The number of identification numbers should match the number of paper incident reports.
Enter the facility name, hall/pod/wing/area, room or location, incident date, time of the incident, and date the hard copy incident report was completed. Dates require (MM/DD/YYYY) format and times require 24 hour format.

a. The first location field is the living unit where the youth or staff is assigned. At Woodland Center, this should be the Pod

b. The second location field is the location where the incident occurs.

Enter the number of staff and youth involved. Default values are 1 and 1; at least one staff or 1 youth must be involved. Ensure that numbers of names of youth and staff involved match with the numbers of youth and staff involved.
Click on **Save Initial Data and Continue.**
Complete the narrative and code the characteristics check box (es).

Note: The Noncompliant in Program checkbox is automatically checked since most incidents are indicative of non-compliance. If not checked on the paper Incident Report, (such as for a youth injured by accident during recreation), the user should uncheck this checkbox.

Complete **Staff Reporting Incident** Select **Save.** Complete **Save Confirmation**.

Enter additional data or modify existing data using the Incident Report Edit function.

Note: When entering youth or staff involved in the incident report, enter the Primary Person Involved first. The following sections assume a youth incident with one staff involved. Youth and staff involved may be added in any order.

Select **Click here to add Youth, Staff, or Other Persons to UIR.**

Enter the type of incident: **Youth, Staff, Other**

Note: The type of incident should be selected for each person. Making this selection will sort the person entered into the appropriate section of the incident report.

For a youth entry, type in the youth's first few letters of the last name, click **Enter**, then select **Click to Select**

For the youth or staff that is the source or cause of the incident, check the checkbox to indicate the Primary Person Involved in the incident.

Note: For assaults, the perpetrator should be designator as Primary Person Involved.

Check the checkbox if restraints are involved (Physical or mechanical or both) for the person in question.

Enter restraint, confinement, isolation, and medical data as applicable. Then repeat for each youth and staff involved.

Note: If the youth is involved in multiple periods of isolation or confinement (e.g. behavior management followed by due process isolation), enter the youth and document the first isolation, then enter the youth a second time to document the second period of isolation.

1.4 PERIODIC THIRD PARTY VALIDATION OF CONSOLIDATION FOR INTERNAL CONTROLS.

In order to show appropriate internal controls for incident reports, each facility must conduct a weekly independent validation that all paper incident reports have been properly consolidated into CV in the JJIS. This validation must be conducted by a facility staff who was not involved in writing the incident reports or consolidating them into the JJIS. A written certification statement of the completion of this validation should be documented in writing and retained at the facility for at period of two years. In order to assist in this validation, use the JJIS Report, Incident Report Consolidation Summary which will provide information for a date range of interest that documents incidents chronologically for the following data:

Number of paper incident reports summarized (based on numerical entry in the field)-None if field left blank
JJOLT Incident Report Main Form Number
Paper incident report numbers entered into the JJIS field
Person saving the Incident Report
Whether the incident report was entered within one day of the incident
Whether the incident report was entered within seven days of the incident.

Note: The Incident Report Consolidation Summary is dependent on information entered in the JJIS The report assists but does not by itself prove that consolidation is occurring correctly.

1.5. EXTRACTION OF INCIDENT REPORT DATA FOR TRANSFER FROM JJIS TO PERFORMANCE-BASED STANDARDS (PBS).

During April and October, BJJ high and medium secure facilities perform a month long data collection for use in preparing the PbS Facility Site Report. PbS processes the information extracted from JJIS incident reports and converts the information into PbS incident reports. Because all BJJ facilities enter incident reports in the JJIS throughout the year, this extraction is transparent to the large majority of BJJ facility staff. With appropriate adjustments, data from JJIS Residential Reports can be used to track some PbS Site Report Outcome Measures on a continuous basis.

1.6 REPORTING OPTIONS USING INCIDENT REPORTS.

Internal Controls- Incident Report Consolidation Summary.

This report is run as a facility report. The report assists facility staff in conducting the third party validation of consolidation of paper incident reports into the JJIS CV. The user selects a date range and the report prints out to display the matching of the JJIS CV with its paper version counterparts. A facility wide percent match is also calculated. This report is only applicable for paper incident reports entered into the JJIS.

Incident Report Facility Summary.

This report is actually a summation run from the Client Select Menu. The user selects the incident report tab, then enters their facility name and a date range. The result is a chronological listing of incidents with a short narrative and status of the corrective action for that incident report. Clicking on the edit button will cause an expanded view of the incident report to appear.

Incident Report by Shift and Characteristic.

This report is run as a facility report. The user sets in a date range and the report summarizes the counts for each incident characteristic by shift and total during the date range. The report also includes average facility population and total days of care for the date range. Counts can be divided by total days of care to obtain rate-based outcome measures.

JJIS Residential Reports

These reports are a series of incident reports by incident type run as facility reports. They are found on the user's JJIS Custom Reports menu and compile based on the user security access. Each report prints out incidents of type in chronological order with the involved youth name, JJIS Mainform number, JJIS Detailform number, and other incident specific data. For example, for mechanical restraints, the type of restraint, location of restraint, and start and stop times of restraint are included as well as if the incident contained injuries. Residential Reports aggregate youth related information from a personal standpoint and work in tandem with the Incident Report by Client feature available from the Client Menu.

JJIS Monthly Business Reports

These reports are run as facility or Central Office reports. For incident reports, the reports created are for Isolations, Confinements, and Isolations and Confinements within a date range.

Incident Report by Client

Incident Report by Client is an option that allows the user to select a youth and date range and chronologically display incident report text for incidents where the youth is involved in that date range. Incident Report by Client is a feature that can be used when reviewing youth performance for treatment planning, court hearings, and preparation for release.

1.7 DEFINITIONS

Note: The definitions in this manual were derived from work with the JJOLT Team and PbS Glossaries. When writing incident reports, these definitions are to be used for proper coding of characteristics. Questions regarding coding should be resolved by referring to the definitions in the manual.

Abuse: Any act or failure to act on the part of a direct care staff or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act which presents an imminent risk of serious harm. *For the purposes of PbS, count only cases of abuse that have been confirmed or substantiated by an outside investigation, usually a state-level child protection agency, attorney general's office, or agency internal affairs*.

Abuse/neglect: An act or failure to act on the part of a parent, caretaker or guardian which puts a youth at risk for serious physical or emotional harm, sexual abuse or exploitation, death or another act which presents an imminent risk of serious harm to the child. All allegations of abuse/neglect are investigated by the Children's Protective Services workers. Abuse/neglect allegations can cause removal from the home of all youth and placement into the Children's Foster Care system.

Accident: An unintended, unforeseen, unexpected, and unpleasant event or occurrence due to horseplay, daily activities, or recreation that results in personal injury, loss or damage. Such accident may occur as the result of actions by another youth, staff, or visitor.

Alcohol/Illegal Drugs: All consumable alcoholic beverages and/or any drug or narcotic not specifically prescribed by a physician or other qualified medical personnel.

Assault: Any instance in which a youth or staff member is involved in a physical conflict with another individual(s), even if no one is injured. This includes unprovoked and provoked attacks and sexual assaults. Distinctions should be made between assaults and fights where fights are defined as mutually instigated attacks. *This distinction was made for analysis purposes to further define assaults. Assault outcome measures will combine these events to create a single score*.

Assessment: An examination, more comprehensive than a screening, performed on each newly admitted detainee soon after arrival to the facility. It usually includes a review of the medical screening, behavior observations, an inquiry into mental health history, an assessment of suicide potential, and an assessment of education levels and competencies. Health and mental health assessments are to be conducted within 7 days of admission, substance abuse assessment within 14 days of admission and educational assessments within 30 days of admission.

Attempted Escape: Any unsuccessful effort or plan to flee from custody or supervision of an institution, training school, detention center, from someone assigned to supervise the youth, or attempts to flee during transportation.

Average Population: Average (or arithmetic mean) population of a Bureau of Juvenile Justice (BJJ) facility. This is calculated by summing the daily population for each day of the reporting period and then dividing the result by the number of days in the reporting period.

Behavior Management: Activities undertaken by DHS personnel to control the behavior of and the application of sanctions to youth placed in DHS operated programs to teach them to accept responsibility and demonstrate appropriate behaviors. A system of rewards, incentives, sanctions and consequences used to decrease antisocial and disruptive behaviors and increase appropriate pro-social behaviors.

Client: Refers to the youth.

Code Violation: Alphanumeric code that identifies an alleged major or minor offense within the youth disciplinary system

Community Justice Center (CJC): Structured low security programs that assist youth released from higher security level residential facilities integrate into community life in a gradual manner. Formerly known as half-way houses or residential care centers.

Confinement: Instances in which a resident is confined for cause or punishment in the room or cell in which he or she usually sleeps, rather than being confined in an isolation cell or room. See room confinement

Contraband: Any item(s) introduced or found in the facility, including improperly possessed drugs (whether illegal or legal) and weapons, that are expressly prohibited by those legally charged with the responsibility for the administration and/or operation of the facility.

Detention: Facilities that provide short term detention services. Youth placed in these programs are detained while awaiting court action. If these youth are charged, adjudicated, and determined to require residential placement, they will be placed in a treatment program. Detention programs normally have a program security level of high.

Due Process: A system for protecting the rights of youth who are subject to involuntary room confinement. Due Process Isolation is the use of room confinement as a disciplinary consequence after a due process hearing.

Duration: Length of time, normally automatically computed when start and stop times are entered for periods of restraint, confinement, or isolation.

Direct Care Staff: Staff members who have routine contact with youths, including Youth Specialists, Youth Aides, teachers, chaplains, group leaders, social workers, counselors, nurses, and other staff who supervise the youth.

Environmental Health/Safety Problem: Any unusual event in the facility and/or vicinity (i.e., severe weather, chemical spills, ice, broken glass, etc.) that poses a risk to the physical well being of persons in the affected area.

Escape: To flee from custody or supervision of an institution, training school, detention center, from someone assigned to supervise the youth, and the unlawful departure of a youth from an institution or from custody while being transported, or failure to return to the facility while on leave.

Escaped Youth Returned to Custody: Youth returned (voluntarily or involuntarily) to the facility from which they escaped, or to another custodial location such as a county juvenile detention facility.

Facility: Name of the facility.

Facility Capacity: Licensed total capacity of an individual facility as approved by Licensing.

Failure to Comply: A youth's refusal to obey facility rules or staff directions that results in an unsafe environment and rises to the level of an incident.

Fight: A subcategory of youth on youth assault. A fight is defined as a mutually instigated assault between two or more youth.

Gender-Specific: Programming and activities that are designed, trained, administered, and evaluated based on the unique characteristics, developmental needs, and learning styles of a specific gender.

Group Confinement: When a group of youth are placed in their rooms during an investigatory (including searches) process or for protection. While a characteristic checkbox is included in the incident report, group confinement requires a multiple page paper IR to document the confinement of each youth who is confined. A group confinement is one incident with multiple confinements.

Horseplay: Wrestling, rough contact, or roughhousing between youths that rises to the level of an incident but is not considered assault by staff.

Inappropriate Language: Use of profanity. Use of racial, ethnic, or gender-based slurs or epithets. Use of slurs with the intent of demeaning one's religion, heritage, or sexual orientation. Use of language in a manner intended to demean, degrade, or harass.

Incident: An event or crisis that may compromise the safety and security of staff and residents, and requires staff response and written documentation. Such events occur within the facility (although they may be precipitated by events outside the facility) and may involve staff, youth, or others. Examples include assaults, escapes, evacuations, vehicular accidents, abuse/neglect, disturbances, or riots. Incident also refers to situations of environmental risk, such as broken glass, blocked emergency exits, etc. Some incidents may be resolved without injury to staff or residents. However, some incidents may result in injury, the use of restraint(s), and/or the filing of misconduct charges that may result in punitive sanctions to youth or disciplinary action to staff.

Incident Rate: The rate at which a type of incident occurs within a facility. This is determined by summing the total number of incidents within a given period of time, dividing this number by the number of days of youth care during that period, and finally multiplying the total by one hundred. The rate is then expressed as the number of incidents per 100 days of youth care. For example, in a facility that provided 1800 days of care in a given month, and also experienced thirty incidents during that month, the incident rate would be 1.66 incidents per 100 days of youth care ((30/1800)*100). This procedure, while complicated, provides a measure of the incidents at facilities, regardless of the relative size of the facility. The process is based on the nationally recognized Performance-Based Standards project.

Injury: Any instance in which a youth, staff member, or visitor is hurt even if treatment is not provided. This includes minor injuries such as scratches or swellings, injuries from assaults/fights, accidental injuries from playing sports or other environmental hazards, and cases where a youth or staff member is injured during the application of restraints.

Intake Watch or Isolation: Use of a designated area or room confinement to provide dedicated observation for a youth who has been newly admitted to the facility.

Intervention: Actions taken by the staff to respond to youth behavior. One or more interventions may be applied to a youth.

Isolation: Any instance when a youth is confined alone for over 15 minutes in a room other than the room or cell in which he or she usually sleeps. *For the purposes of PbS data collection, this does not include protective isolation (for injured youths or youths whose safety is threatened), program separation, routine isolation at the time of the youth's admission, or isolation that is requested by the youth. (See also Room confinement)*

Lost Keys: Any keys, personal or work related, that are lost on site or work site keys which are lost off-site.

Lost Tools: Any tools lost on the work site.

Mechanical Restraints: Mechanical devices used to prevent an uncontrollable youth from injuring himself/herself or others. Mechanical restraints may only be used for short periods of time. Restraints should never be used as punishment or misconduct. Examples of mechanical restraints include handcuffs, ankle chains, and padded or soft restraints.

Med Count Error: When the number of dosages of a labeled medication package is noticed to not correspond with the recorded amount on the Medication Administration Record. For example, if there were 30 doses of antibiotic X and documentation that 5 had been dispensed, a count should result in 25 remaining doses. If the count was not equal to 25, this would be a med count error.

Medical Attention: Medical treatment dispensed by a physician, nurse, or physician's assistant, or at WJ Maxey Boys Training School (a Medical First Responder (MFR))

Medical Watch or Isolation: Use of a dedicated area or room confinement for a youth who is unable to participate with their group for medical reasons (e.g. flu).

Noncompliant in Program: A youth's refusal to obey facility rules or staff directions that results in an unsafe environment, and rises to the level of an incident. (See also Failure to Comply).

Other: All individuals who are not neither resident youth nor full-time facility staff. "Others" may include student interns, guests, visitors, contractual staff, and non-facility state/county employees (such as JJS workers).

Other Contraband: An incident report checkbox to be checked when contraband other than weapons or illegal/drug/alcohol is discovered. For example, unauthorized food in a youth's room would be other contraband.

PbS Youth ID: A random number assigned to youths by the facility. For BJJ purposes, the youth JJIS ID will be the PbS Youth ID.

Physical Restraints: Facility authorized and trained holds used by staff to subdue an otherwise uncontrollable youth in order to prevent the youth from injuring himself/herself or others.

Primary Person Involved: A selection applied to one person in the incident report. Primary person involved in the major driving force behind the cause of the incident. Normally primary person is a youth, but in the case of staff accidents or visitors, primary person can be staff or other persons. For fights, which are mutually instigated, primary person should be assigned arbitrarily unless it is obvious who should be primary. The assignment of primary person in a fight does not of itself imply greater guilt or fault, and should not be used to justify more severe consequences.

Property Damage: Willful destruction, damage or misuse of property belonging to the State, County, or another individual. Destruction of clothing, books, and other items and materials issued to youth as part of their stay at the facility is considered property destruction.

Qualified Staff: Unless otherwise specified, the term "qualified staff" refers to workers who meet the federal, state or local qualifications to perform a certain facility function (e.g., administer a health assessment.)

Refused Medication: Any time a youth refuses prescribed medication regardless of the reason for the refusal.

Room Confinement: Instances in which a resident is confined for cause or punishment in the room or cell in which he or she usually sleeps (own room), rather than being confined in an isolation cell or room. Resident maybe transferred to a designated unit for confinement (e.g., a segregation or program separation unit.) Room confinement may occur in locked or unlocked rooms but cannot occur in large dormitories. (See also Isolation)

Scarring: See Tattooing/Scarification.

Screening: Administration of a tool to identify persons in need of more in-depth evaluation or treatment *(US Dept of Health and Human Services, National Strategy for Suicide Prevention, p. 202)*. A screening instrument, using standard forms and following standard procedures, used to identify immediate risk-suicide, health, mental health, substance abuse and educational needs upon arrival of a newly admitted youth to a facility. At minimum a screening includes an interview, questions or test of a youth and review of available records in accordance with a screening instrument and relevant policies. Screenings should be administered by trained and qualified staff.

Self-Injurious Behavior/Self-Harm: Youth engaged in behavior that causes harm and is indicative of a youth not effectively dealing or coping with the events and activities. *Youth engaged in self-injurious behavior need to be referred for additional mental health services and require increased frequency of monitoring and supervision.* The various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses, or exhibiting deliberate recklessness. (See Suicidal Behavior and Suicidal Ideation below.)

Sexual Misconduct: Any sexual language or behavior, whether assaultive or not, occurring between youth and youth, youth and staff, or between youth and other persons.

Staff Directed Restraint: Any restraint conducted by a peer group on a peer which is directed and supervised by a staff member.

Staff Involved in an Incident: Staff who are present and participating in the incident as indicated by their actions and/or verbal behavior.

Staff Restraint: Any physical restraint executed by staff members only.

Staff Sexual Misconduct: Any sexual language or behavior, whether assaultive or not between youth and staff

Status Offense: Acts or actions which, if committed by an adult, would not be considered a crime, e.g. running away from home, school truancy and disobedience.

Suicidal Behavior: Suicidal behavior includes attempted suicides, suicidal gestures, self-mutilations, intentional injuries to self, and developing a plan or strategy for committing suicide. Unlike suicidal ideation, suicidal behavior usually involves some overt action or thought by youths, indicating intent to injure or kill themselves. Suicidal behavior does not include tattooing or gang rituals involving scratching or cutting (scarification) (see Injury). All other instances of self-mutilation and of suicidal gestures must be classified as "suicidal behavior" because it is impossible for facility staff to know the youth's true motivation. *For more information, see the PbS Resource Guide, Suicide Prevention in Juvenile Corrects and Detention Facilities at http://www.PbStandards.org.*

Suicidal Ideation: Self-reported thoughts of engaging in suicide-related behavior. This means a youth verbally expresses thoughts or fantasies about committing suicide or verbally expresses a desire to kill himself or herself. This does not include cases where the youth develops a plan or strategy for committing suicide, because planning suicide is considered suicidal behavior. *US Dept of Health and Human Services, National Strategy for Suicide Prevention, p. 203*

Tattooing/Scarification: Self-inflicted, or youth-to-youth, permanent marking or cutting for the purposes of adornment and/or expression of gang affiliation. This behavior is counted as an Injury.

Theft: Taking property without the permission of the rightful owner.

Tools: Any instrument of work – such as a screwdriver or hammer – that is not commonly found in the possession of a resident youth and is considered to be contraband.

Transport: Used in the context of youth restraint; transport coded restraints are distinct from behavior restraints. A restraint for transport involved the use of restraints for a brief period of time for on-campus or intra-facility movement where the youth is otherwise stable and compliant, but the staff exercises personal discretion to apply restraints.

Vacancy: a bed or "slot" that is not occupied by any youth and could be filled by an appropriate placement from either the court or JJAU

Weapons: Any item, whether traditional or locally created, where use is intended to cause harm and may be used to threaten the safety of others. Guns, ammunition, explosives, knives, sticks, sharpened toothbrush handles, sharp points fashioned from the metal band off a pencil, shards of ceramic, cutlery/silverware etc., should all be considered as weapons.

Youth: refers to an adjudicated minor who is or has been involved with the Courts and may be placed with DHS for care and supervision OR supervision is retained by the Court

Youths Involved in an Incident: Youths who are present and participating in the incident as indicated by their actions and/or verbal behavior.

1.8 INCIDENT REPORT BACKGROUND INFORMATION.

1.8.1 Discussion and Philosophy

Incident reports document and support the monitoring and improvement of conditions of confinement in juvenile correction and detention facilities. Safe, secure, orderly conditions of confinement provide an environment that supports effective and efficient therapeutic treatment for youth and safe and rewarding working conditions for staff. Incident report data provides youth numerical and rate-based information to monitor and assess progress in reaching and maintaining desired outcome measures that serve as indicators of facility performance. Staff can refer to incident reports to monitor youth behavior on an individual basis for treatment planning, preparation for transition to the community, and release from the secure facility.

The incident report is a factual recounting of an event and carries the status and significance of an official statement. Each incident may involve one or more youth or staff and is composed of one or more smaller events that are called characteristics. For example, an incident may include a youth who is non-compliant in program, the youth's use of profanity, an assault by youth upon a staff, an injury from the assault, a restraint to stop the assault, and a confinement to control the youth following the assault. Each of the smaller events is a characteristic. In an incident report, each youth and staff is documented within the context of the incident. For example, if three youth are mechanically restrained as the result of a fight, staff code the incident as a fight, non-compliance with program, and three mechanical restraints. If three staff are involved (for example, in applying restraints, de-escalating youth, supervising the restraint), there are three paper incident reports written, but there is one Computerized Version (CV) entered into the JJIS. The CV reflects the names of the three youth, the names of the three staff, appropriate descriptive narrative, and appropriate coding including the fight, the noncompliance with program, and the coding for the three youth who are mechanically restrained.

The relationship between the paper incident report form and its development in the JJIS warrants special comment. In JJIS, the incident report consists of a main form and may include one or more detail forms. The main form and detail form work in a hub and spoke arrangement where the main form contains common foundation information (Facility, Date/Time of Incident, Location, Person writing the IR, Consolidation Information, narrative) and the detail form contains youth or staff specific information. For example, youth restraints, youth isolations, any injury, and medical issues are delineated in the detail form.

As a general rule, since this is an incident report and not a youth report, as much information as possible is loaded into a single incident report as possible. There may be cases where there are exceptions but normally this rule will hold true. In cases where the incident lasts a significant period of time, it may be prudent to end one incident for reporting purposes and start another. In these cases, it is also prudent to reference not only the incident in the narrative but to describe if the incident is also being documented on a separate incident report.

Consider the example below:

A youth has been demonstrating consistent unacceptable behaviors that disrupt group function. Various techniques are employed to resolve the situation within the group, but the problems persist. A Special Behavior Plan is written that requires the youth be removed from the group to receive individual treatment and supervision. During the 12 days where the Special Behavior Plan is in effect, the youth spends significant time away from the group and is subject to six different periods of room isolation that vary in length between 2 hours and 18 hours. The youth also requires mechanical restraint with handcuffs twice and refuses medications on three occasions.

Comment: An incident report could be written to cover the whole 12 days or separate incident reports can be written. The key points are to include all reportable characteristics without counting the same event more than once. Similarly, if a youth is isolated three days in a room for suicidal behavior on day one, the correct course of action is to document one event of suicide behavior and three days of isolation.

1.8.2 Data Accuracy.

The goal of data accuracy is to ensure that each incident is properly and uniquely documented while conforming to common organization criteria including:

a. Definition compliance
b. Document completeness (reporting and administrative criteria)
c. Supervisory review
d. Numbering of paper incident report forms
e. Consolidating paper incident report forms
f. Entering the CEV into the JJIS within required time limits since the incident occurred.

Data accuracy is affected by several factors

RTP-(Real to Paper)-a measure of the ability to record what happened in reality on the paper IR form. When this happens perfectly, a score of one is assigned while when it does not happen at all, a score of zero is assigned.

DC-Definitions and Coding-Standard definitions are applied to observed events that results in events being converted into data elements in a standardized process. An out of control youth being handcuffed is coded as a mechanical restraint. A perfect score is again equal to one.

I-Inclusion-Measure of Consolidation (Paper IR to JJOLT IR); Maximum is 1

T-Timeliness-Measures completeness when the database is queried for information of interest. RTP, DC, and I are expected to be near perfect after a certain time.

Assuming full compliance with a incident reporting timeline set by policy, a maximum score for timeliness is 1.

U-Uniqueness-Measures that each incident is only documented once. Maximum score is 1.

Data Accuracy can then be considered the product of these five factors and accuracy of reports based on incident report data can be maximized by:

Real to Paper (RTP)-Documenting every appropriate event as an incident.
Definitions and Coding (DC)-Using a standard definition set and applying definitions to observations correctly and consistently.
Inclusion (I)-Properly consolidating paper versions into their JJOLT version.
Timeliness (T)-Knowing that all applicable incident reports are resident in JJOLT
Uniqueness (U)-Knowing that each incident is only documented once.

Data Accuracy = RTP x DC x I x T x U; Maximum Value is 1 or 100%

JJOLT Incident Report Review Guide (Revision February 2006)

The following is a review guide for incident reports in JJOLT. The JJOLT incident report is a summary of one or more paper versions of the incident report (PV). The JJOLT incident report is a reflection of the information contained in the paper versions that are completed by staff.

1. Are entries for hall/pod/wing/area and specific room or location present and appropriate?

2. Does the number of paper incident reports and number of Paper IR ID numbers match?

3. Is the date/time of the incident logical (not in the future)(not the default 0000)?
   Is the date the incident is logged on of after the incident date?

4. Is the incident entered into JJOLT within 24 hours of the incident (compare incident date/time with JJOLT ID number (0622006ABCDEFGHXXXX) AB is month, CD is day of month, EFGH is time)?

5. Is at least one youth identified in the Youth Data Section of the IR? Is the number of youth in the Youth Data Section consistent with the youth identified in the IR narrative? For fights, youth on youth assaults, and youth threatened by youth are at least two youth identified?

6. Is at least one staff identified in the Staff Data Section? Is the number of staff identified in the Staff Data Section consistent with the staff identified in the IR narrative? Is the staff reporting the incident listed in the Staff Data Section (required)?

7. Is one person identified as the Primary Person Involved? Normally, the primary person is the cause, reason, or source of the incident. Most primary persons are youth.

8. Review the narrative for content. Does the narrative answer all questions? Are abbreviations spelled out the first time they are used? Is the narrative consistent with checkboxes that are checked? Restraints should be identified as physical and/or mechanical. Assaults should identify perpetrator and victim. Medication refusals should identify name, dose, and time of medication. Noncompliant in Program should be checked for almost all cases other than an accident. Is the use of LSCI documented where appropriate in terms of techniques used and results? Term meanings must comply with the terms in this manual.

9. Checkbox checks-verify at least one checkbox is checked for each IR. Checkboxes are independent (i.e. checking one checkbox does not mean that other related checkboxes can be left unchecked)

10. Based on narrative content, are cases of suicidal behavior, self-harming behavior, and assault addressed for occurrence of injuries and nature of medical treatment provided?

11. For injuries, is the source of the injury identified? Is the medical treatment provided documented including date/type/by whom or the fact that there was no medical treatment identified?

12. Do all mechanical restraints, confinements, and isolations have a starting date/time and ending date/time? Are all end dates/times in the present/past?. Are any start and stop times the 0000 AM Default? Do any duration calculations exceed 5 days (this may be indicative of the wrong end date)?

13. For each confinement, is the confinement reason and confinement type identified (multiple reasons or types within a single confinement are not allowed)?

14. Is there a name in “Report Written By” (This should be the name of the person entering the IR in JJOLT)?

15. Are there names for Reporting Staff and Supervisor at the end of the JJOLT IR (These names come from the paper IR)?

Notes:

Juvenile Justice On-line Technology

JJIS

Training Manual

EDUCATION DEPARTMENT

Pre-Logon Basics

Start/Programs/Internet Explorer

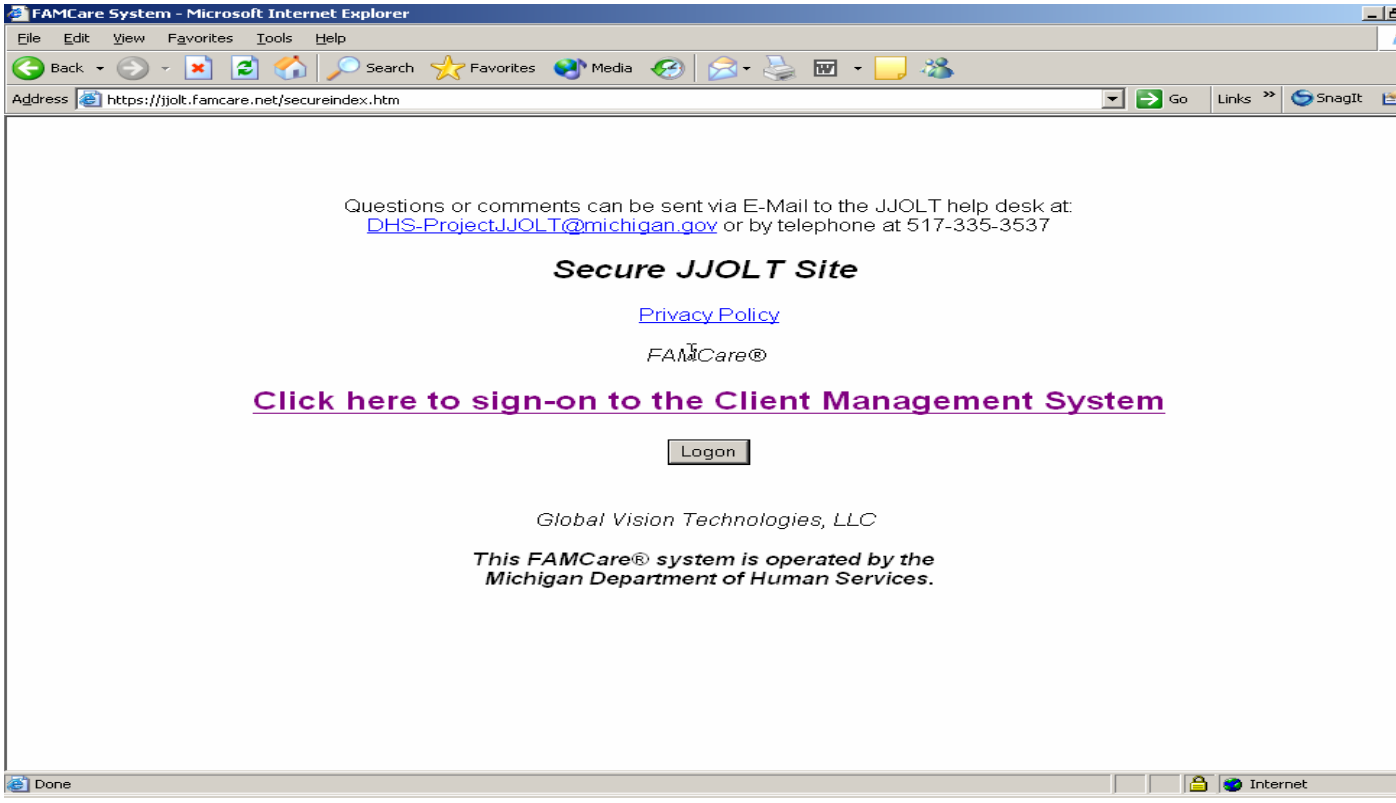
JJIS Training Site: HTTP://JJOLTTRAINING.FAMCARE.NET

JJIS Live Site: HTTP://Famcareaccess.com/JJOLT

JJIS Help Site: HTTP://JJOLTHELP.FAMCARE.NET

E-mail address: DHS- ProjectJJOLT@michigan.gov

The screen below is the sign-on screen for JJIS for DHS. Place your cursor on the line that states "Click here to sign on to JJIS" and press the left button on the mouse or hit the "Enter" button on the keyboard.

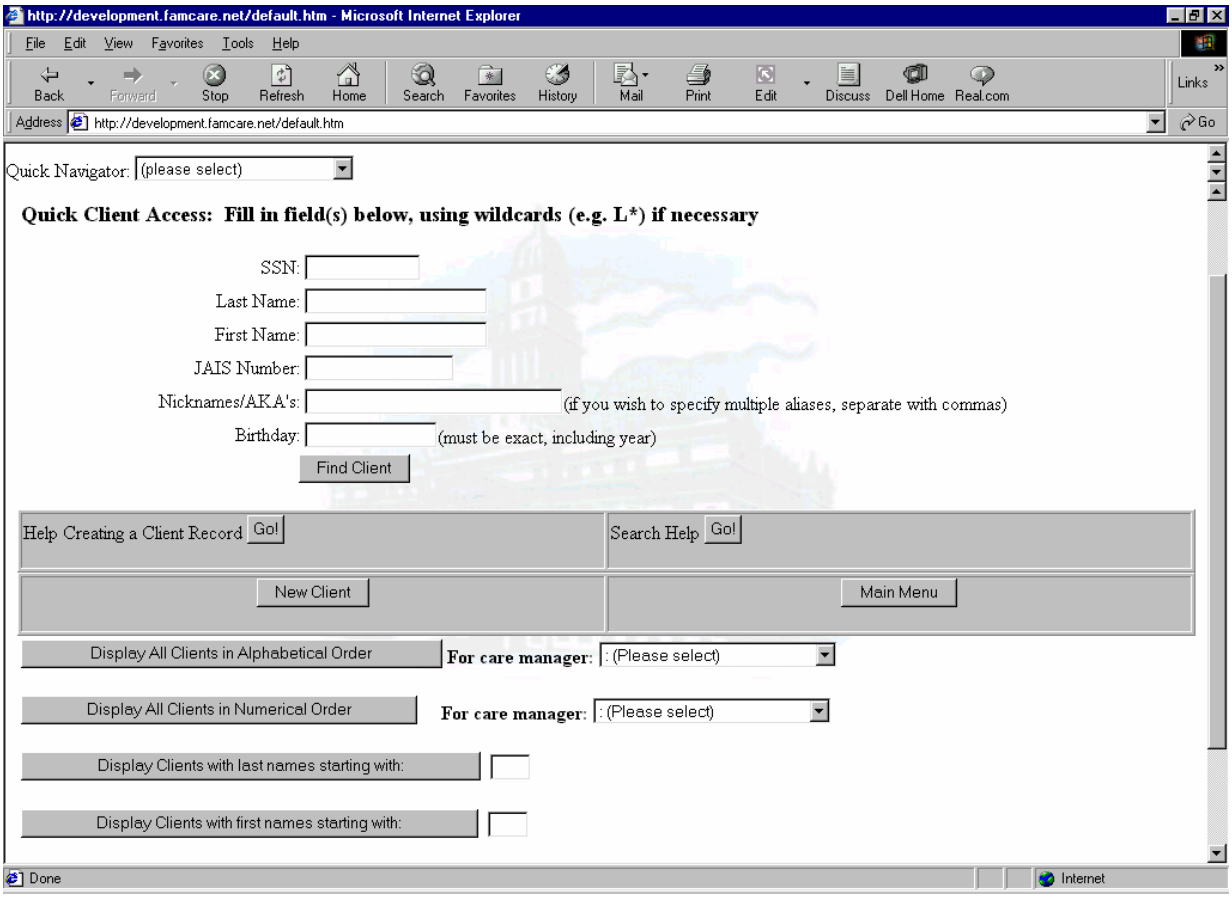


This brings up the sign-on screen, as well as a gray screen that contains the "Redistributable Code Agreement." Click on the "OK" button on that screen, which will then leave the sign-on screen, as shown below.

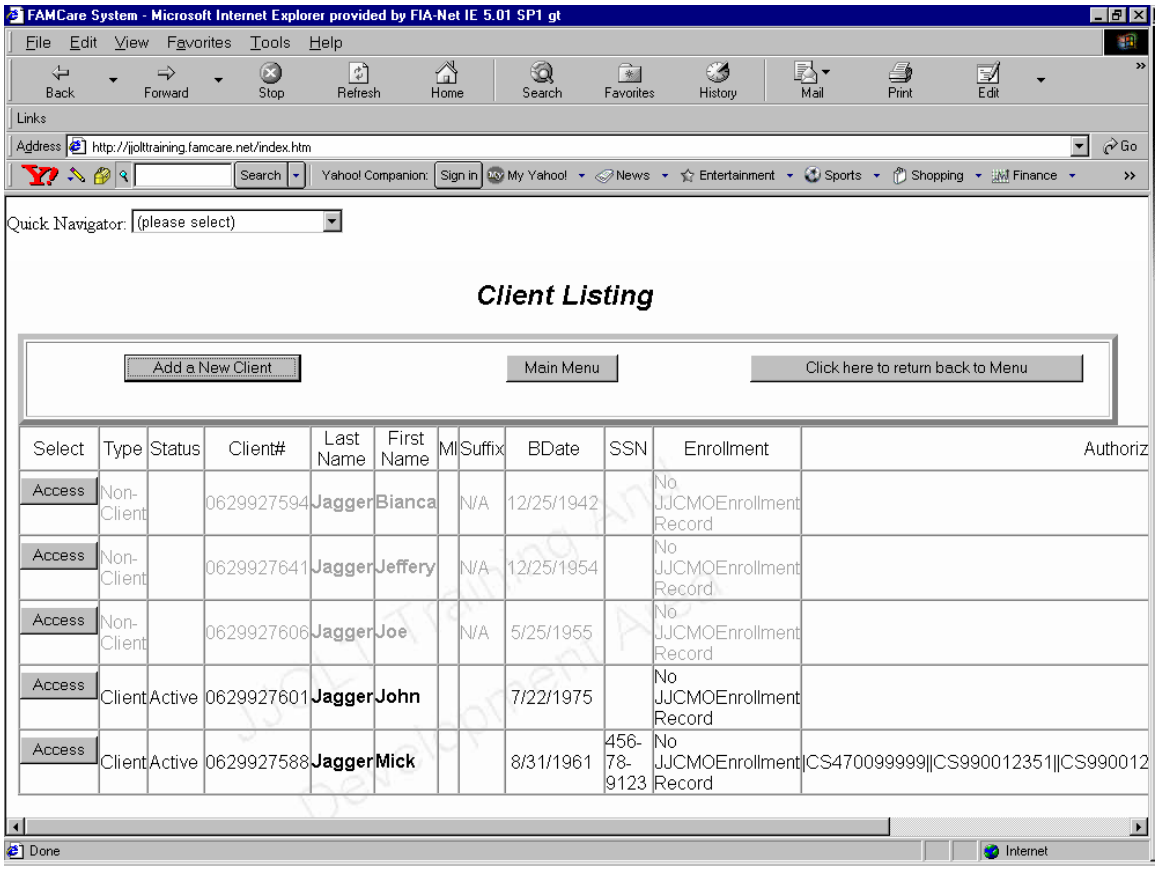
From this sign on screen, enter your user name (First Name-Last Name) and initial password you are given (123456), **then go down to "New Password" and create your new password**. Confirm it, then click on the "Logon" button. This will produce the main master session menu (next page). **DO NOT CLICK ON LOGON UNTIL YOU CREATE YOUR NEW PASSWORD. YOU MUST CREATE YOUR OWN UNIQUE PASSWORD THE FIRST TIME YOU SIGN IN. THE PASSWORD MUST CONTAIN 6 CHARACTERS, OF WHICH AT LEAST TWO MUST BE LETTERS AND TWO MUST BE NUMBERS.**

You will then get a message that your password has been successfully saved.
Click to continue.

This will be the initial screen you view when you sign on. This is a client specific program and you must search for your youth's record.



To generate a list of Clients using the "Quick Client Access" section, select a field (preferably Last Name) and type the first few characters that are known, then add an asterisk (*), which is a wild card (for example Ja*). This will produce a list of Clients that have those characters in common. **Please search for as few characters/letters as possible**. This is very important when we have clients that have difficult spelled names, or we have two kids with the same name, but different birthdates etc… When you get the screen that lists all the records, you can see which clients are "active," which are "enrolled" etc… To access a specific Client, click on the "Access" button next to the Client's number and name. This will bring up this youth's record and you can begin to add updated information.



If you do not see the client's name on the list, please check spelling and try again. Should you still obtain no match contact your system support coordinator. YOU WILL <u>NEVER ADD a NEW CLIENT.</u>

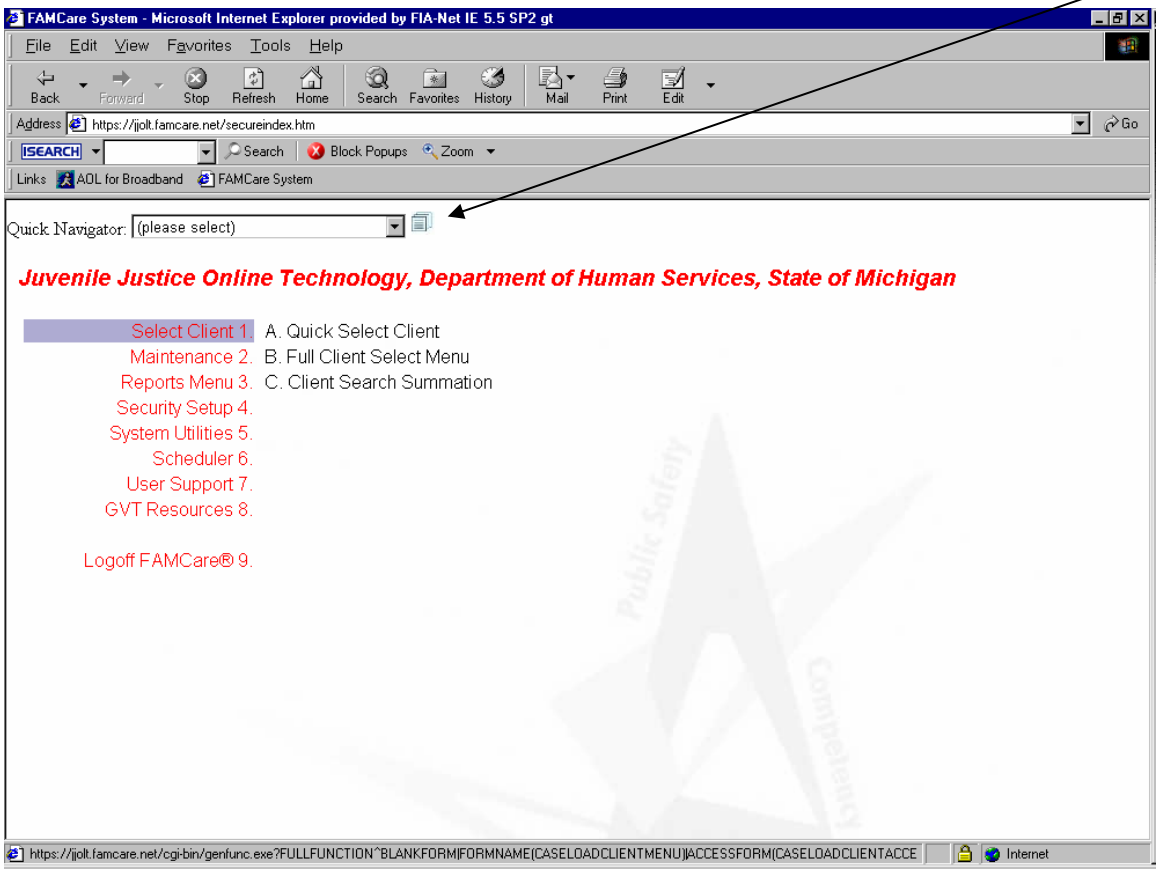
Quick Navigator

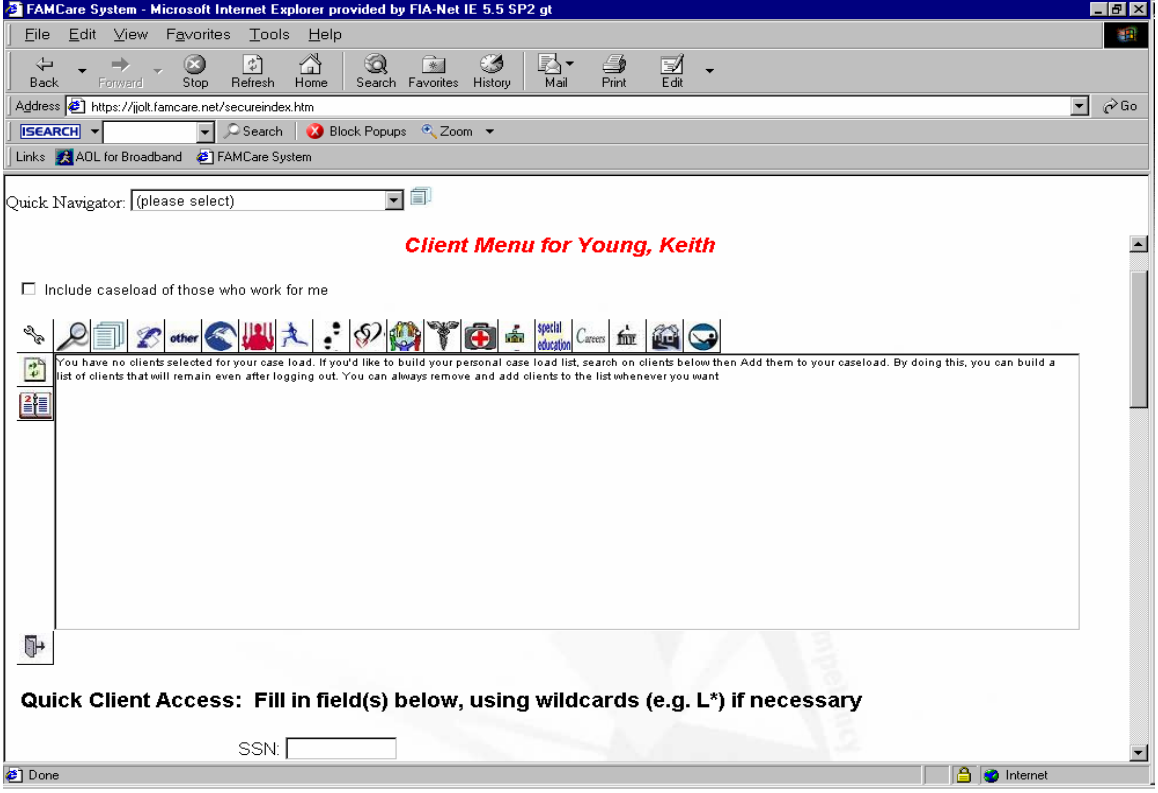
At the top of the main screen there is a "Quick Navigator" bar. Clicking on this field produces a small dropdown menu of the different areas for which the user has been granted access. This allows users to move around the system to avoid backing out of various screens to reach the main menu. You can return to the "Client Menu" screen to search for another client, or you can go to the Main Forms menu for the client you are currently working on, or you can Log Off the system. **If you see this Quick Navigator you always know you are in the main screen, and this is how you move around the system. <u>Do not use the button at the top right hand side of your screen to close out, this will take you out of the system, and you must start all over, and you may lose information you were working on</u>. The same is true for the "Back" button, you may not save the information you were working on. Get in the habit of using the Quick Navigator.**

Case Build Manual

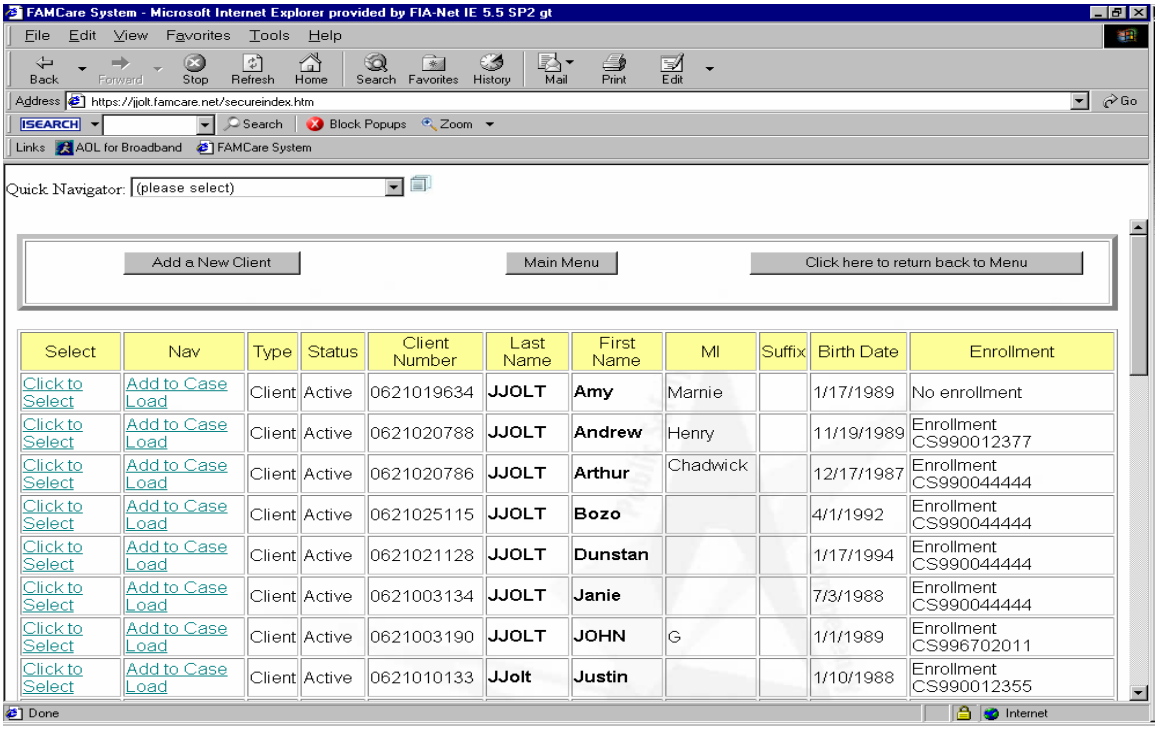
JJIS Case Load Build- allows a worker or manager to build a case load of clients for easy reference, the Case load can then be modified by the user to display range of information on clients in a chart form (e.g. Gender, DOB, Race, and Religion). In addition, the feature includes icons within the case load screen that allow the user ready access to client related forms (for example, medical, treatment, incident, and education) without having to navigate through multiple screens and pushbuttons.

You will be able to access the case build after logging into the system, next to the quick navigator



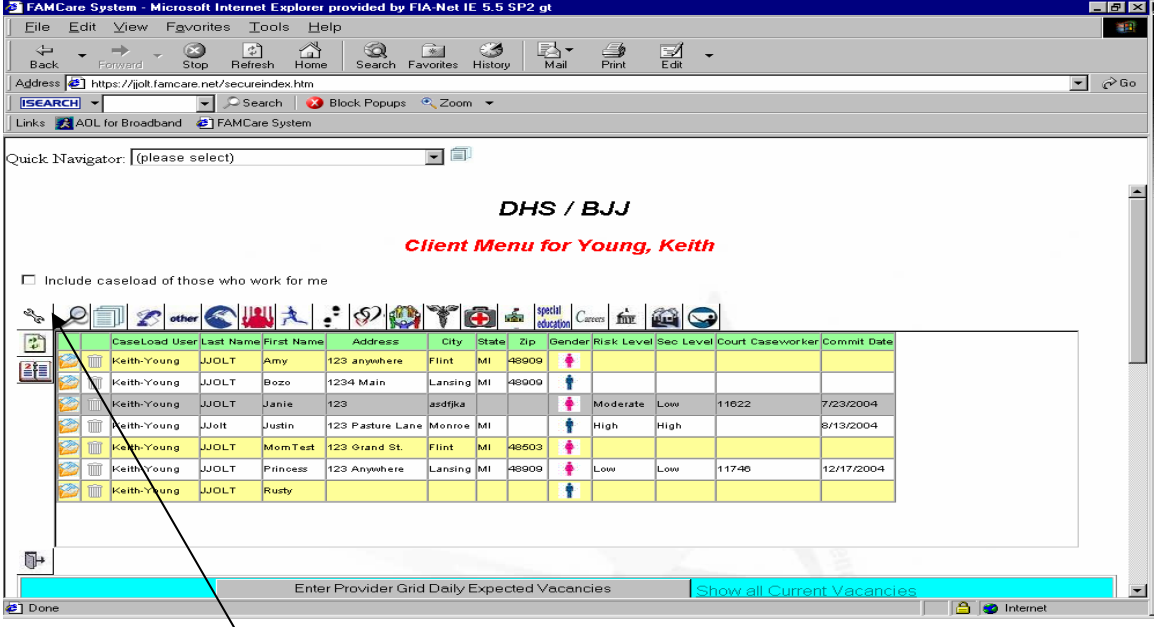


In order to build your caseload you must search for the client you want to add, by using the search screen at the bottom of the page.



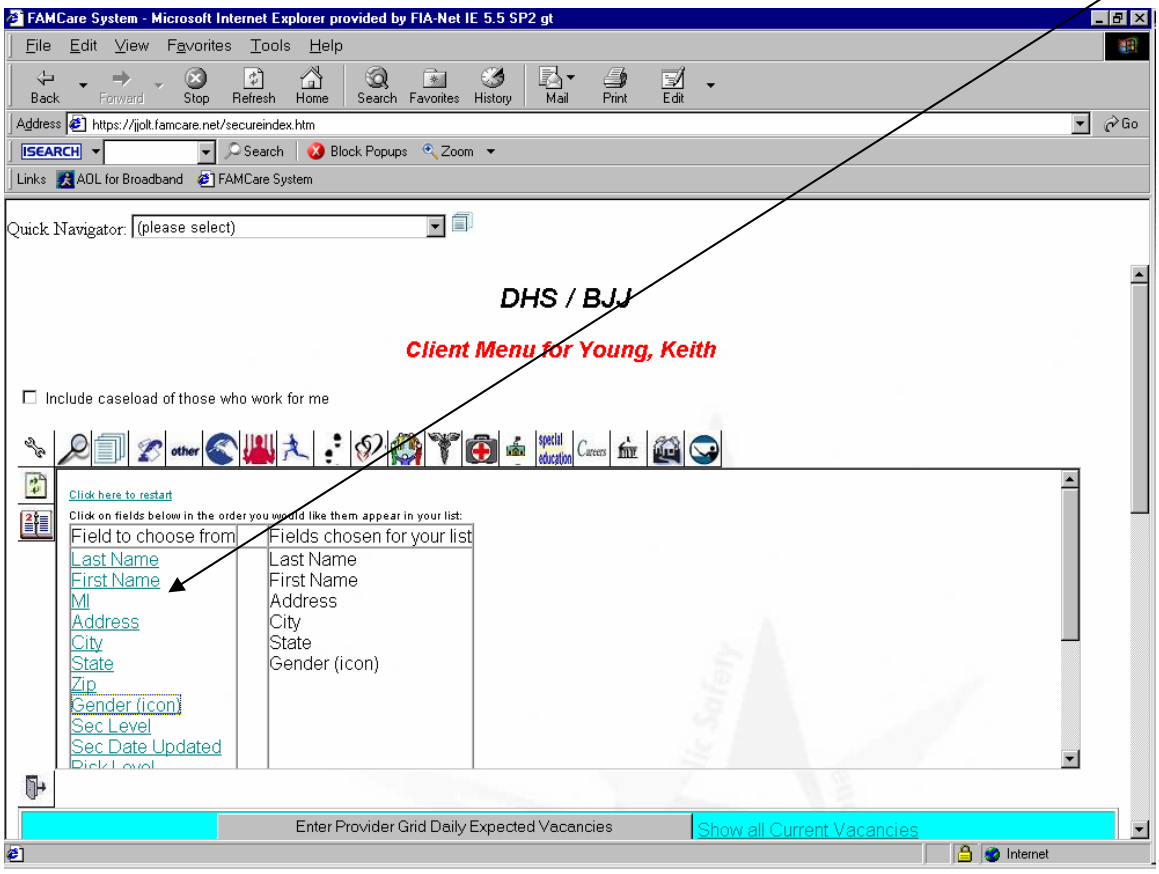
You can either click to select (view case record) or add to your caseload. By adding to your caseload, you will begin the caseload build process. You also have the ability to select which fields you would like to view on your screen. By clicking on the link next to the quick navigator, this will allow you to view your summation screen of clients on your caseload.

Please see example on next page



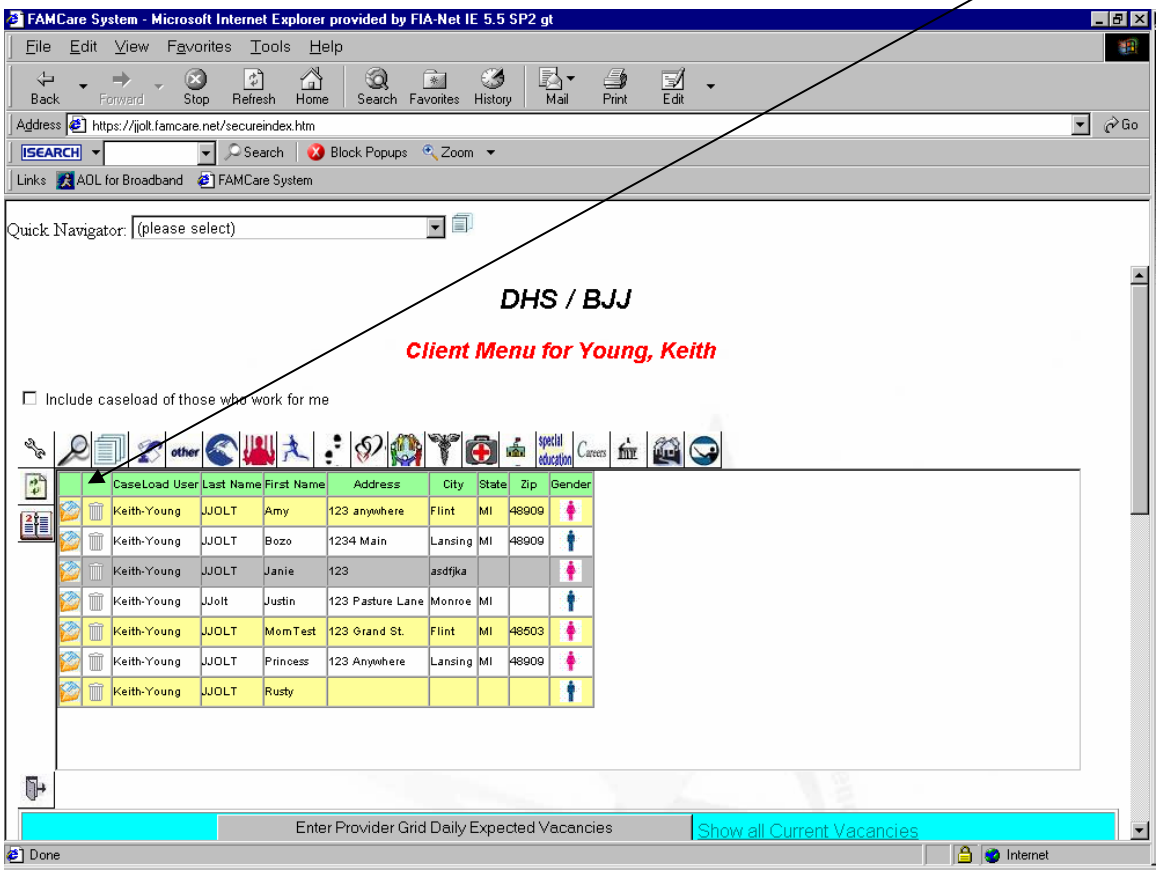
To select which fields you would like to view on your screen, click on the wrench which represent (configure my caseload listing).

You can now double click on which fields you would like to view on your summation page.



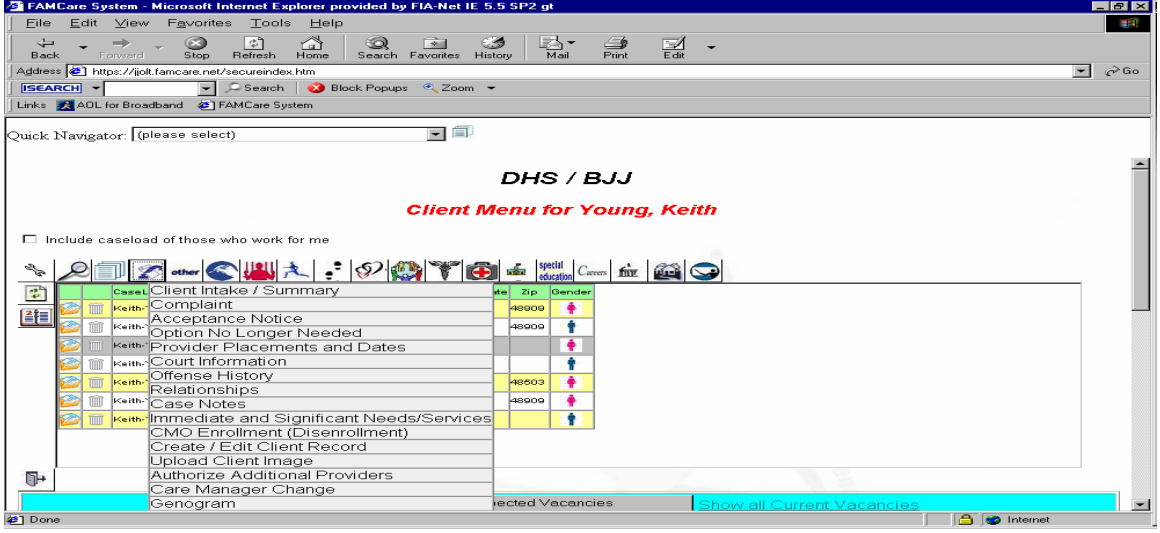
At the bottom of your screen, there is a link that will allow you to save the list that you selected.

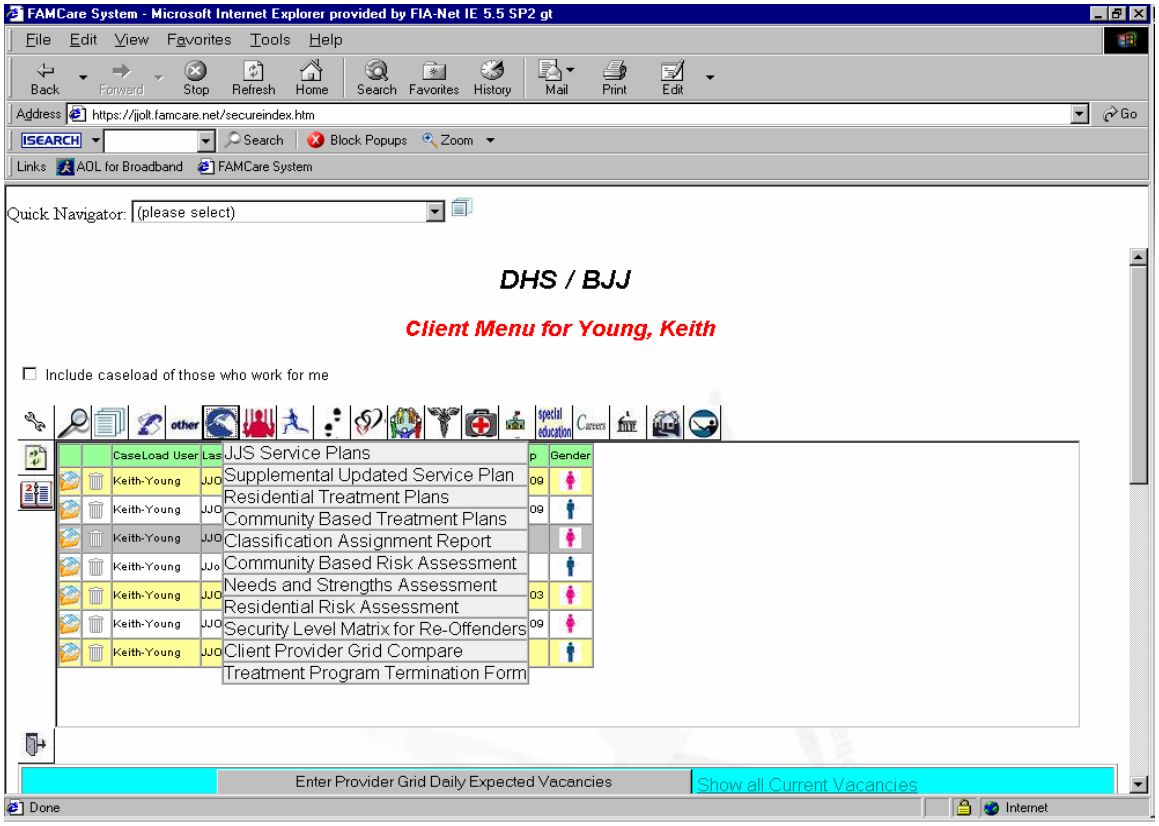
At this point you can either view your case record or remove from your caseload



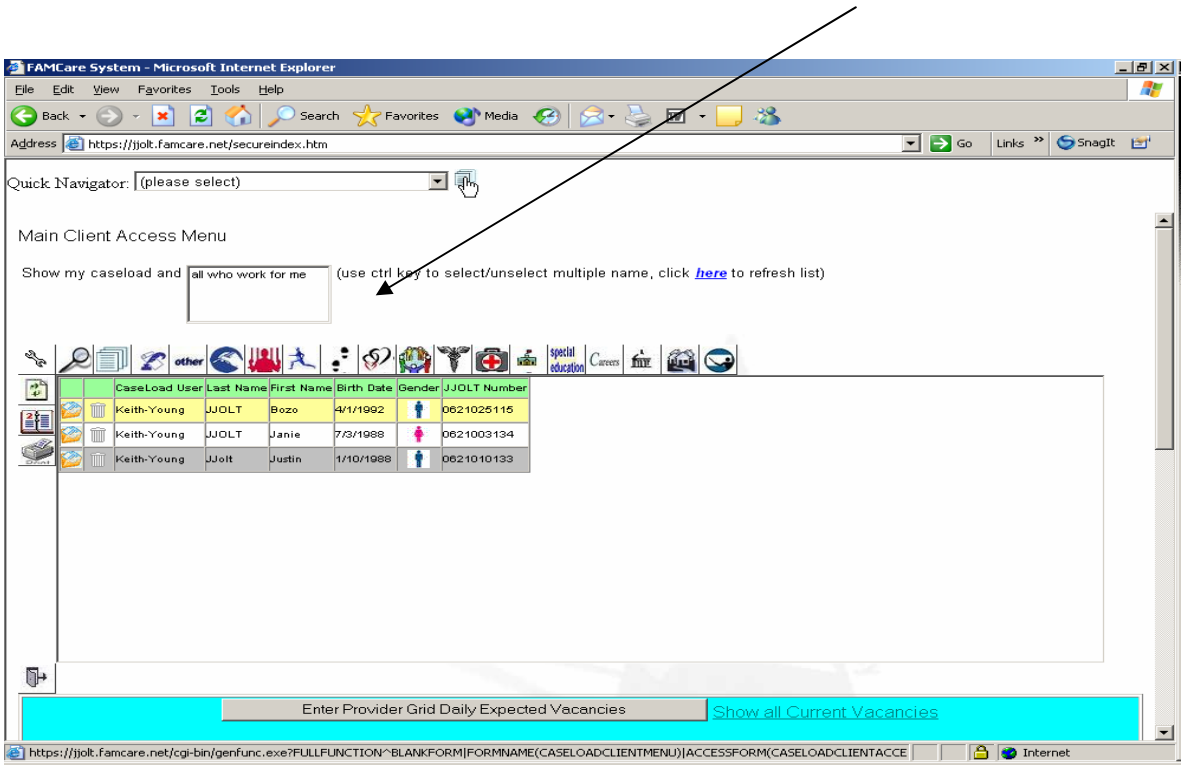
When you access your case record it will be shaded in gray. The icons across the top represent the numbers on your forms menu, i.e. Intake summary, Treatment Plans, Service Plans, Education, etc.

Please see next page


FAMCare System - Microsoft Internet Explorer provided by FIA-Net IE 5.5 SP2 gt
File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail Print Edit
Address https://jjolt.famcare.net/secureindex.htm
Links AOL for Broadband FAMCare System
Quick Navigator: (please select)
DHS / BJJ
Client Menu for Young, Keith
Include caseload of those who work for me
Client Intake / Summary
Complaint
Acceptance Notice
Option No Longer Needed
Provider Placements and Dates
Court Information
Offense History
Relationships
Case Notes
Immediate and Significant Needs/Services
CMO Enrollment (Disenrollment)
Create / Edit Client Record
Upload Client Image
Authorize Additional Providers
Care Manager Change
Genogram
Show all Current Vacancies
Done
Internet

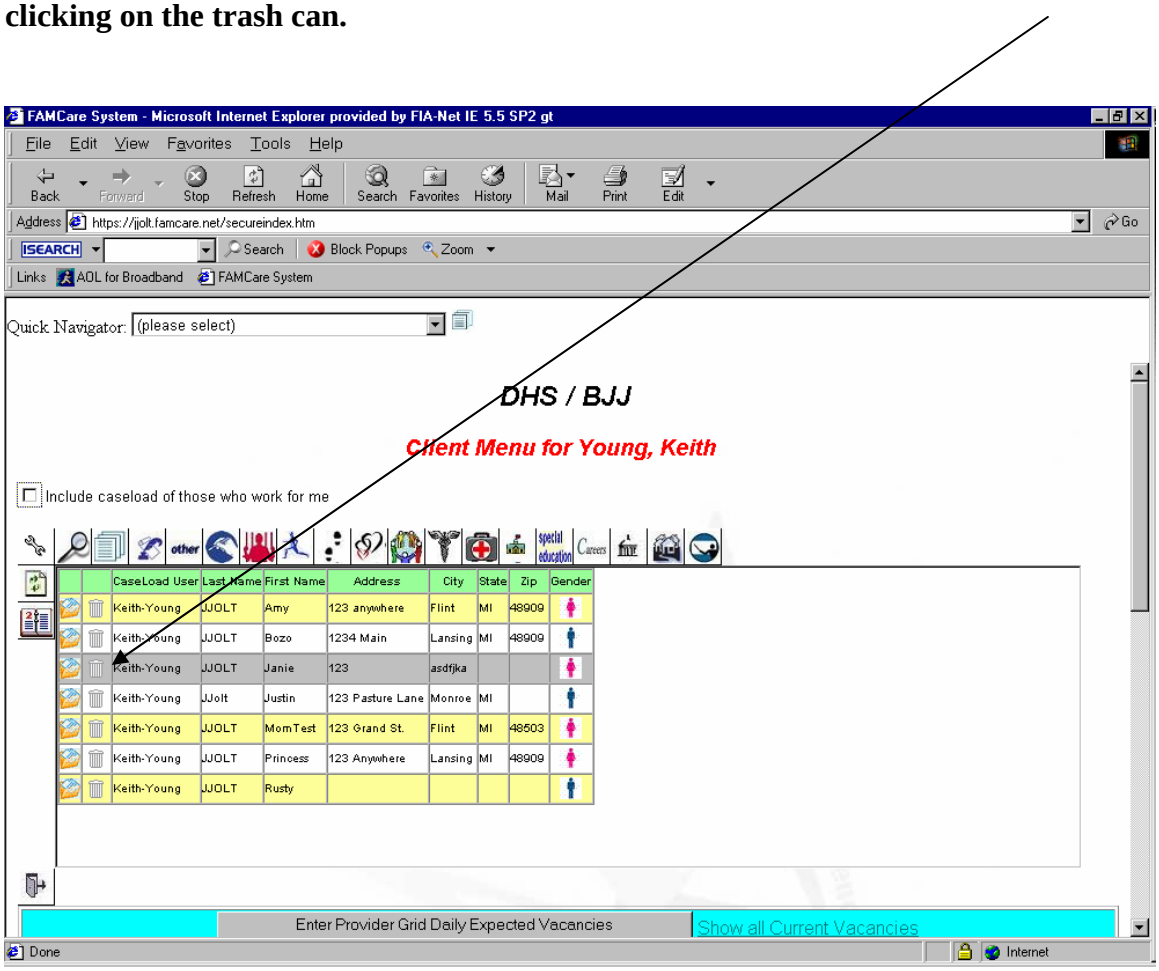

FAMCare System - Microsoft Internet Explorer provided by FIA-Net IE 5.5 SP2 gt
File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail Print Edit
Address https://jjolt.famcare.net/secureindex.htm
Links AOL for Broadband FAMCare System
Quick Navigator: (please select)
DHS / BJJ
Client Menu for Young, Keith
Include caseload of those who work for me
JJS Service Plans
Supplemental Updated Service Plan
Residential Treatment Plans
Community Based Treatment Plans
Classification Assignment Report
Community Based Risk Assessment
Needs and Strengths Assessment
Residential Risk Assessment
Security Level Matrix for Re-Offenders
Client Provider Grid Compare
Treatment Program Termination Form
Enter Provider Grid Daily Expected Vacancies
Show all Current Vacancies
Done
Internet

For Managers and Supervisors, you will be able to view case records for all of your staff in the case build format. Click on the name of the staff , then click here to refresh (caseload of those who work for me).



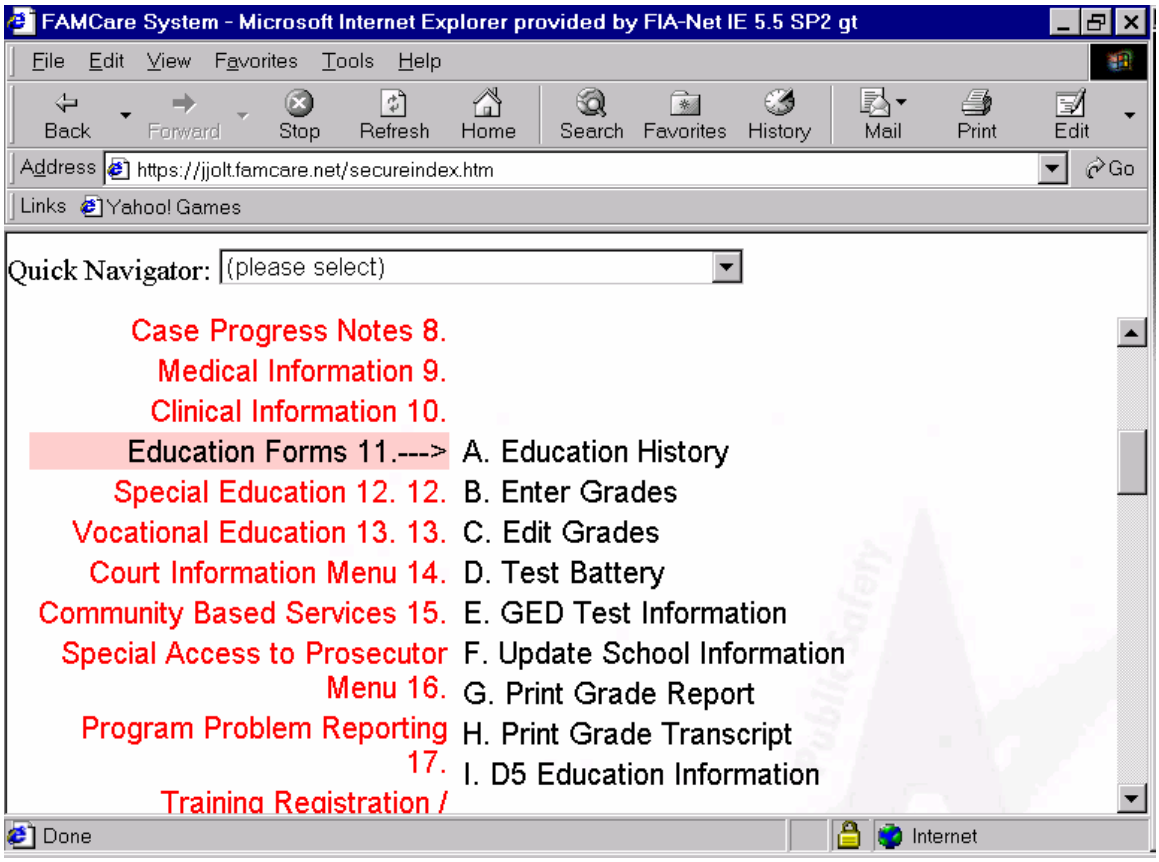
You will then be able to view the caseloads for each of your staff.

Once a client is released and no longer part of your case load, you can remove them from your list by clicking on the trash can.



Forms Menu

The top of the page contains the Client's system-assigned number as well as name. The forms are organized into categories. To open a form, select the category on the left column and then click on it, which generates another list of forms. As each form is built, it automatically populates other required forms for this same Client.

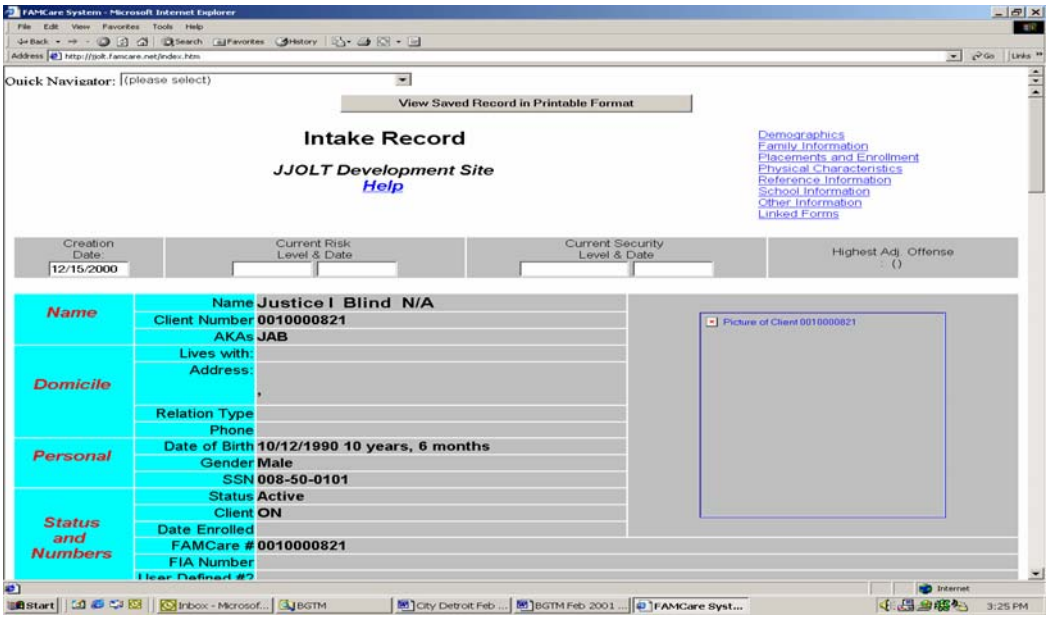


Client Intake Forms (Menu Option 1-A)

Building a Client Record

The "Client Intake / Summary," form continues for many pages. It is the critical form for entry into the system. Note at the top of the form the Client's current Security and Risk Levels. These are pre-populated from Risk Assessments. There is also a box with the "Client's Highest Adjudicated Offense," which is pre-populated from "Offense History."

The top of the "Intake Record" form also shows links to various sections of the form, which are just shortcuts vs. scrolling down the page. The "Intake Record" also contains links to several other screens that supplement the basic Intake form. There are detailed "Help" screens that walk a user through the Client record building process. Select the proper "Go" button for the necessary help.



Other Links on the "Intake Record"

Other links are described below, which allow for more complete data entry during the Intake process. These screens can also be accessed later through the "Forms Menu."

Regarding all the items in this section, once input is complete, click on "Save" to save the input or the "Back" button on the browser menu to cancel the input. An option exists on the "Save Confirmation" screen to also print out a hard copy of the record. Completion of this task and hitting the appropriate button on the "Save Confirmation" screen will take the user back to the "Forms Menu" for that Client.

Case Notes

Click on the ***Add Case Notes*** anywhere from within 1A, from 1I, or 8B.

8. You will type in the date the case note occurred, time is optional.
9. Select the type of contact from the drop down box.
10. Select the contact person (you can select multiple people by hitting your control button and your mouse at the same time to select or deselect multiple people). If your contact is not listed, you will click on ***Add Contact***, and refer to Parent Guardian info section to create a contact and relationship. Also you can check whether the JJS was a part of this case note by checking that box.
11. Remarks are a brief description of the case note that will appear on your Plans. Description is a more in-depth text of what occurred. Someone would have to open this case note up directly to get this description.
12. Select where you want this case note to populate i.e. Treatment Plan, Service Plan (for JJS workers only) Medical etc… Most of you will always select Treatment Plans. **(YOU MUST MAKE A SELECTION IN ORDER FOR THE CONTACT TO APPEAR ON PLAN.)**
13. There is a Private box these are notes that only you will have access to. No one else will even see that they were created. This is generally used for the Clinical Psychiatric staff, but if you use this selection these will not show up on Treatment Plans.
14. Your choice then will be to either **Quick Save**, which will then allow you to add another case note and so on until you have added all that you wish, or **Save/Close** which will save that case note and return you to the main form you were working on. (You can also cancel the case note and return to your form etc…) The schedule button is not a functional part of the case notes section at this time. Your case notes that occur within your Treatment or Service Plan reporting periods will automatically show up no matter where they were created from provided that you follow the above-mentioned instructions.

Parent/Guardian Information

The "Parent/Guardian Information" link provides significant information regarding all contacts involved with the Client and the treatment plan. Each Contact record will contain data regarding that person's relationship with the Client, privileges, role in treatment, demographics, insurance (if applicable) and possible restrictions regarding visitation. This screen is also referred to as "Contacts" and "Contact Detail" under the "Intake Forms" section on the "Forms Menu."

Continue to Scroll through the Intake Record adding all information available. Case manager is the JJS worker. Committing County and Referring County, Committing Offense, Religion etc. At the bottom of the screen you will see links for Offense History, Medical /Psychological Information, medication Information etc. Add all information that you have available. If you do not have it, that is OK, only add what you know.

Previous Placements and Dates

The "Previous Placements and Dates" link produces a form used for placing the Client with service provider(s). There can be more than one provider, as long as they are authorized; however, a primary provider must be designated. (These can be automatically updated by "CMT Authorizations done by the JJAU.") Note: The System Administrator handles information regarding authorized providers and contract details. You must sign this form to save it. If this is a new youth record and you know some previous placement history, please add this. Always follow your screen instructions.

Offense History

This form is self-descriptive, allowing for input of the Client's offense history. For each Offense, and Adjudication date and status must be filled in.

Physical/Psychological Information

This form is self-descriptive, allowing for input of the Client's current physician and psychiatrist, the date of the last physical exam, and notes. A link is also provided to the Medications and Immunizations forms.

Medication

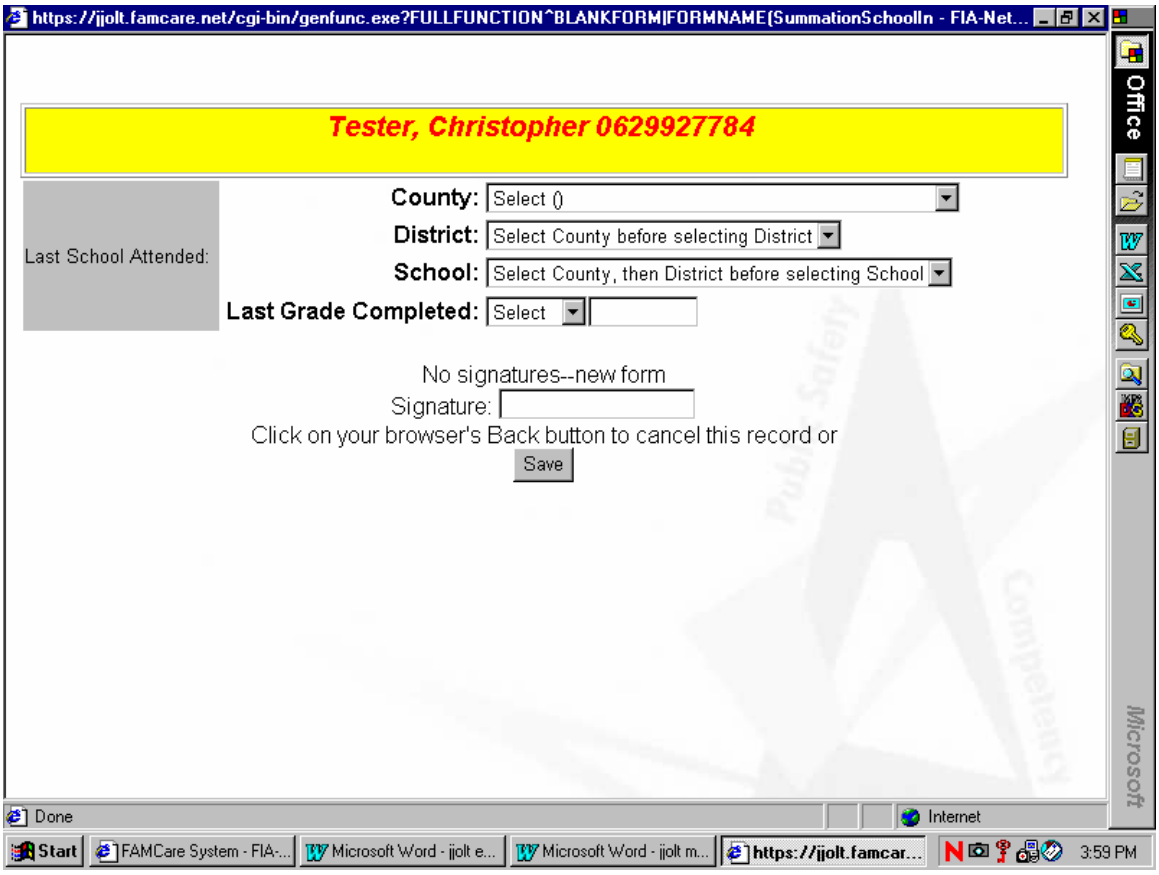
The "Medication" form is used to document all medications prescribed for the client, including prescription number, pharmacy name, referring physician, dosage and any special instructions. Each type of medication requires a separate record, which can also be updated.

Immunizations

The "Immunizations" form is used to document any immunizations that the Client has received and also to input those that are necessary but not yet received (or expired).

Immediate and Significant Needs and Services to be Provided

This form consists of text boxes for special notes regarding the physical needs of the Client and/or emotional needs of the Client and parent.



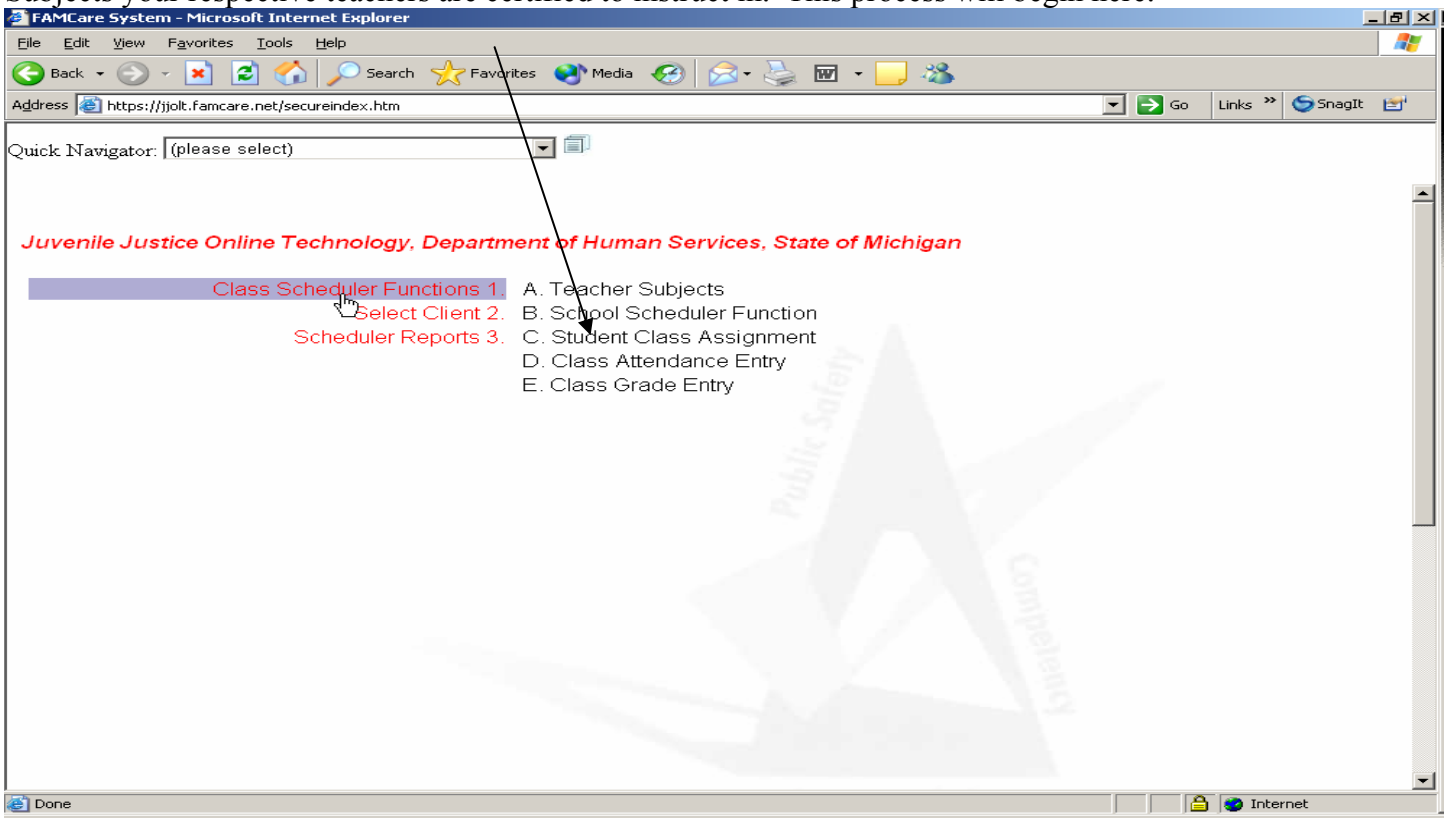
Last School Attended Information

To add last school attended information - 1A, 11A or 11F:

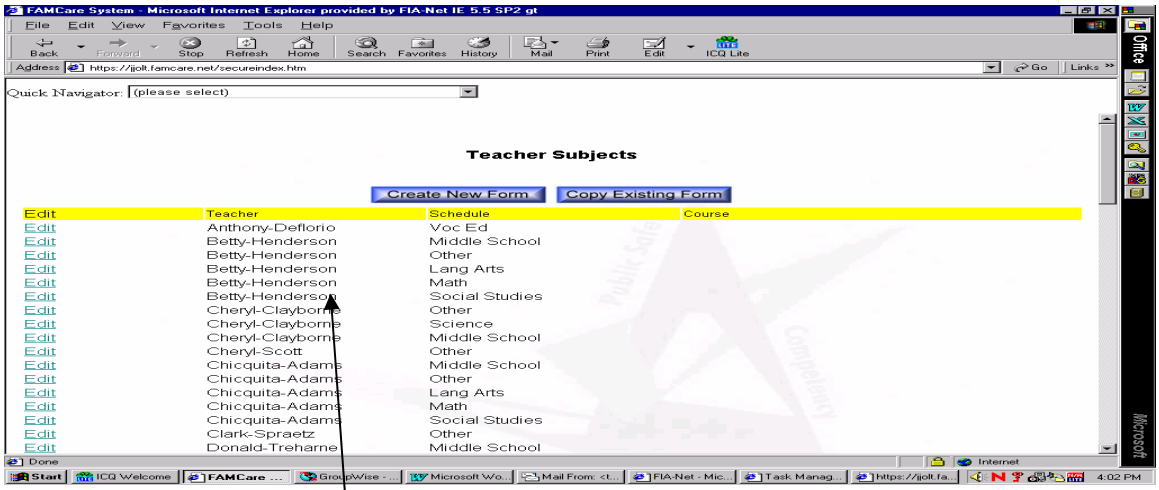
1. Select "Click here to add new school info".
2. Select "County" from drop down list. The system will provide a list of districts within the identified county.
3. Select "District" from drop down list. The system will provide a list of schools within the district you identified.
4. Select "School" from drop down list.
5. Select "Last Grade Completed" from drop down list 1-12 and Other. If you select "Other" tab to next box and explain "Other".
6. When data entry is complete, click on the "Save" button.
7. Save Confirmation Screen appears. Click gray bar at the bottom of screen "Click here to close this screen and refresh summary".

Class Scheduler

You should begin the Class Scheduler process by identifying the
Subjects your respective teachers are certified to instruct in. This process will begin here:



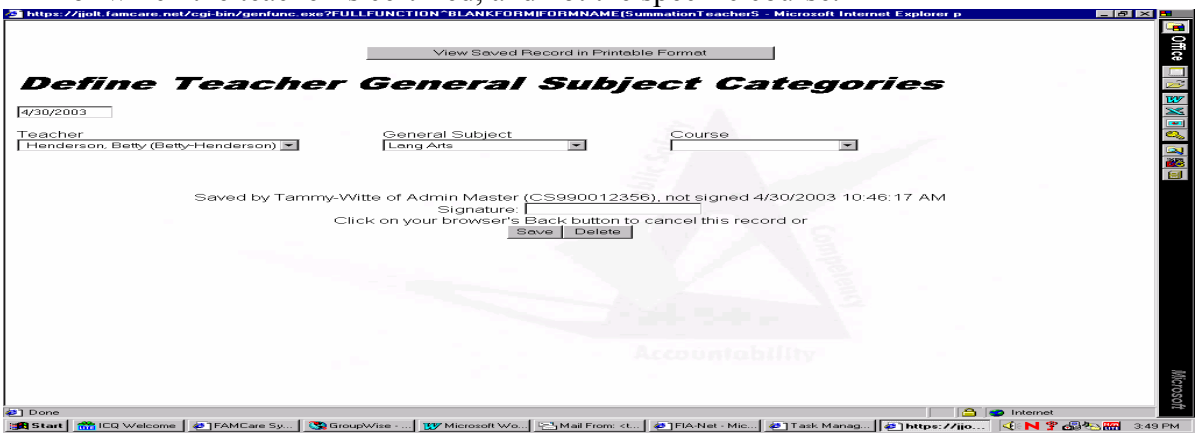
After you select Teacher Subjects, you will arrive at the following Screen, which initially, unlike this one will be blank.



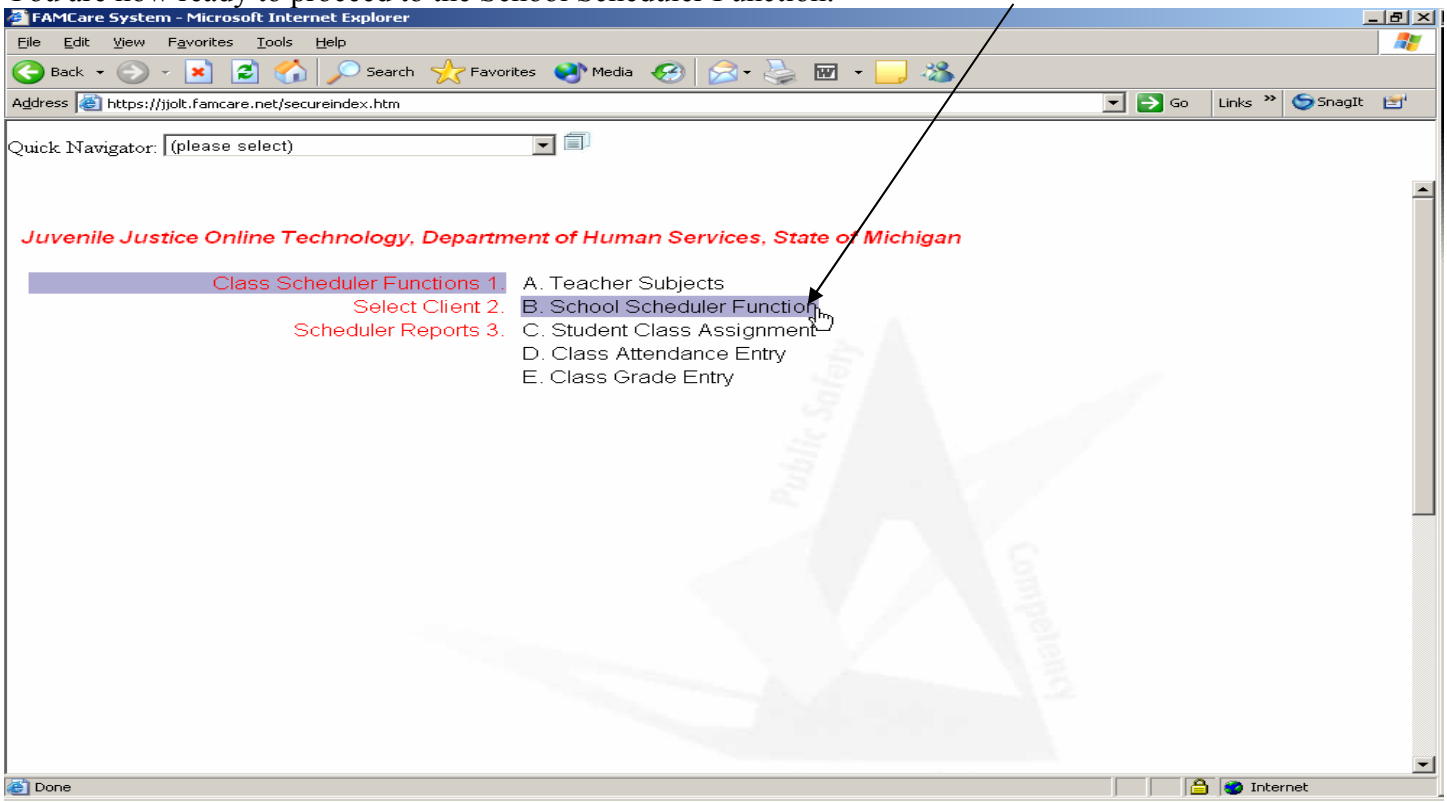
Next as you can see you will add each respective teacher for as many subjects as they are eligible to teach. Note, "Betty Henderson" appears on this list for multiple subjects.

Next, we will examine the actual form used to enter the respective teacher and their areas of expertise:

As you can see this form is relatively brief and to the point. It appears at this point that we are only listing the General Subject
for which the teacher is certified, and not the specific course.

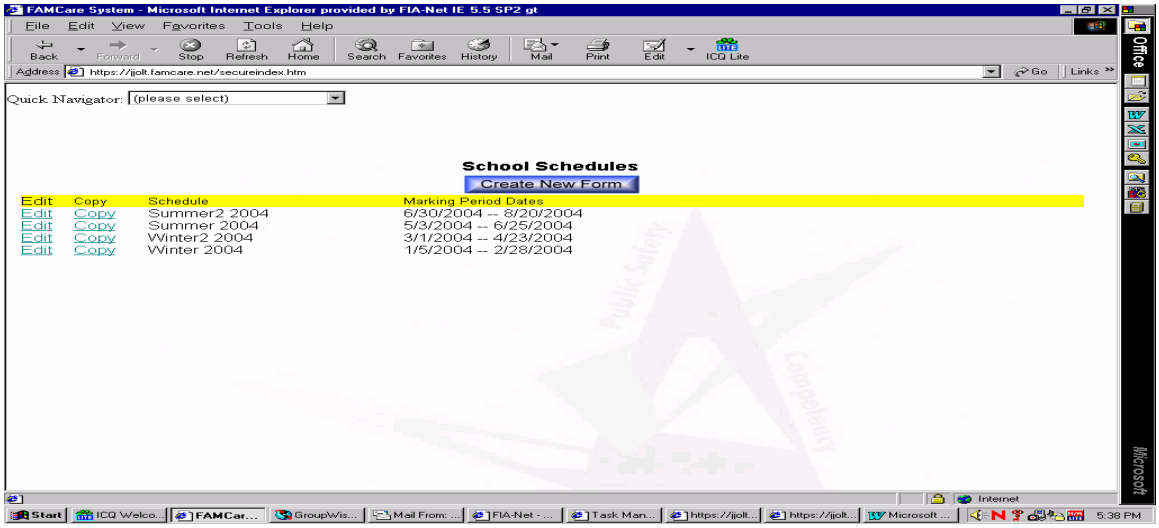


After you have completed this process for all of your teaching staff.
You are now ready to proceed to the School Scheduler Function:

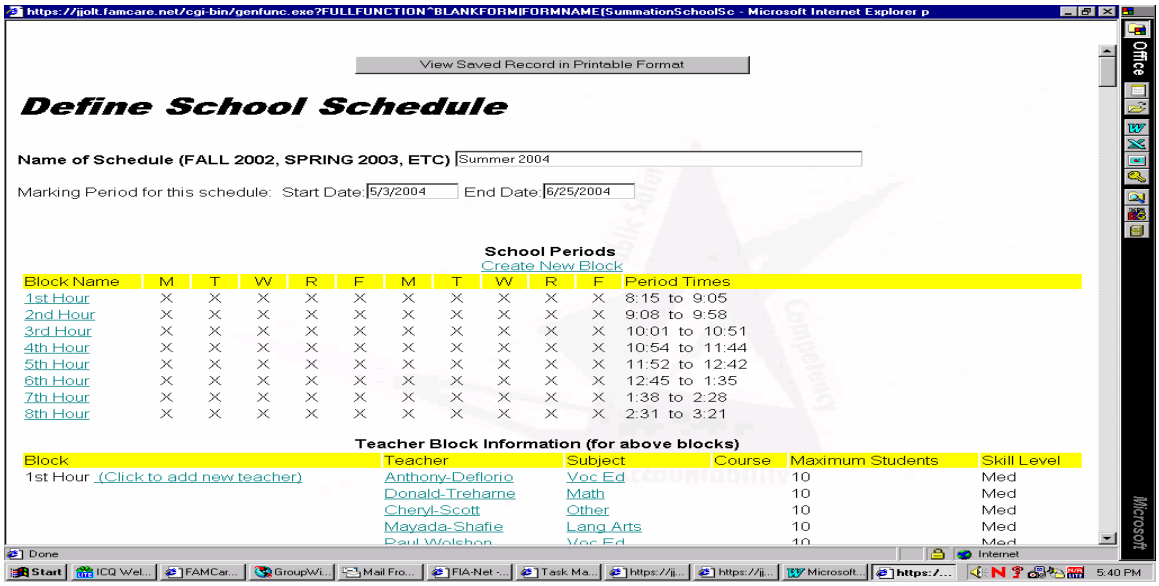


Now, at this point you select School Scheduler Function and proceed to select the appropriate marking period to edit, or create a new form if this is a new schedule.

As you can see from the following illustration, we have already created several school schedules, so we will proceed to edit an existing Schedule. The school periods are user defined. The Teacher Block information is basically accomplished by listing each teacher for the number of subjects they are endorsed to teach per class



period (for combined level campuses).

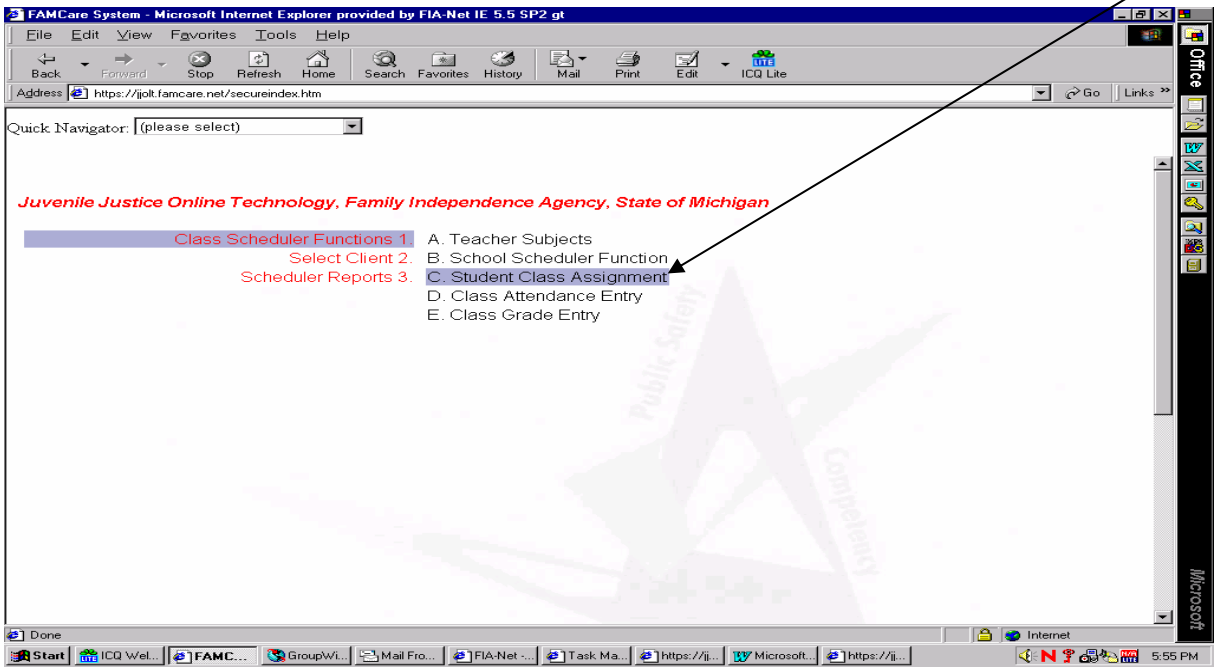


In the event teachers are not teaching combined courses across class periods it would not be necessary to enter a teacher and their respective content area but once for the "Block Hour."

For example in its present configuration at the Maxey Campus Donald Trehame could conceivably - in his first hour class have youth enrolled for Math, and also Middle School. Needless to say, this type of configuration involves much more labor to input, as for each class period you could have to enter each teacher multiple times.

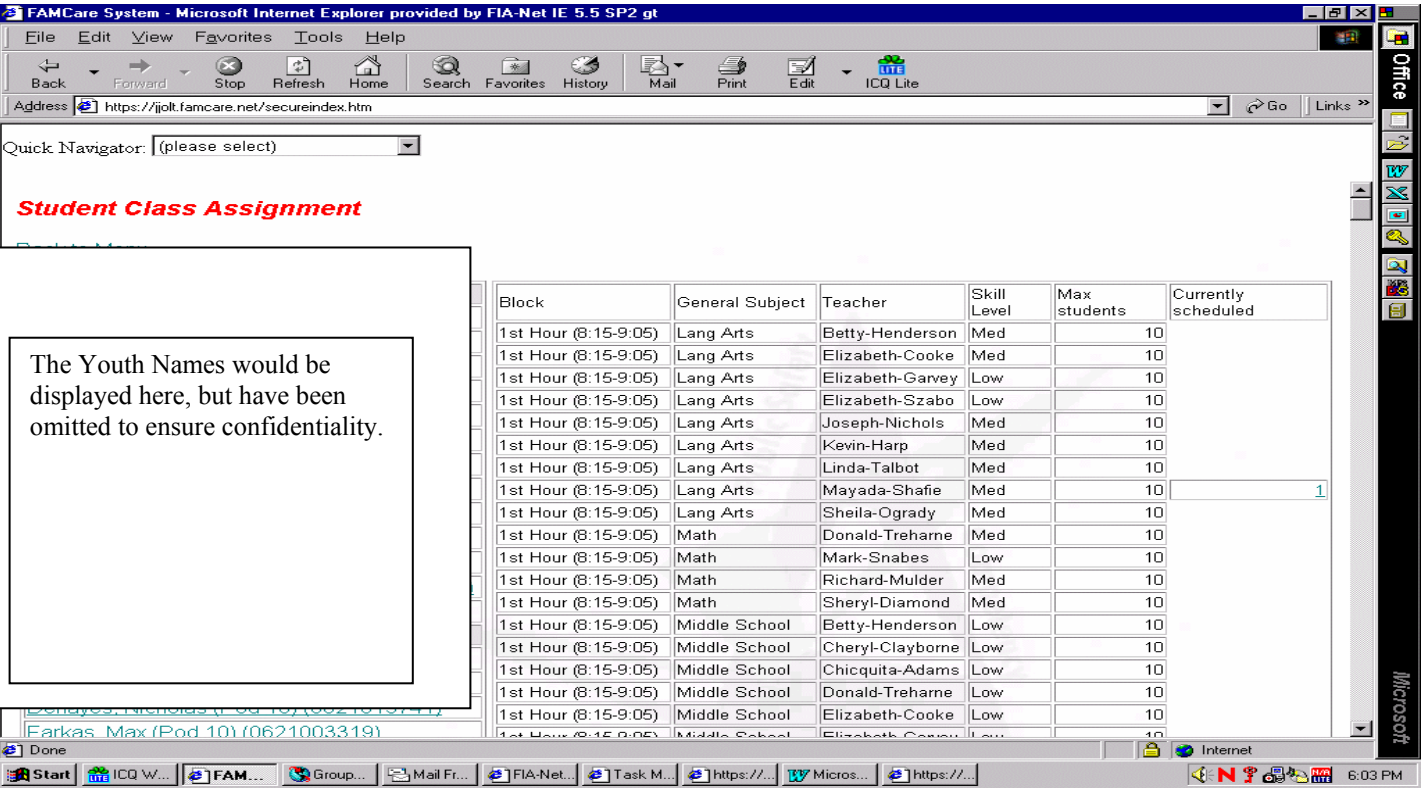
After you have completed this process you should save the form in question until you are ready to resume this process.

Now you are ready to begin scheduling students to their respective classes.

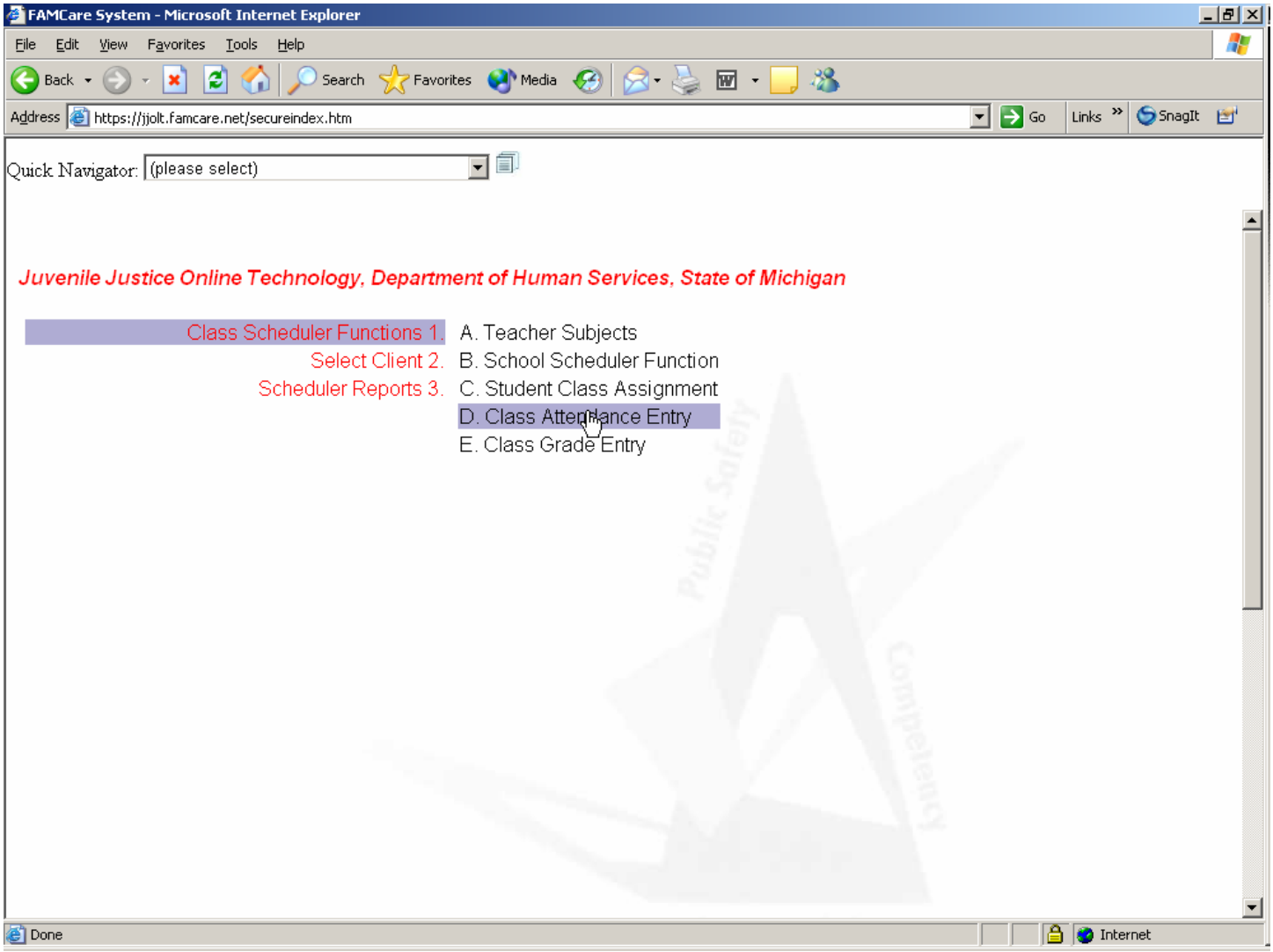


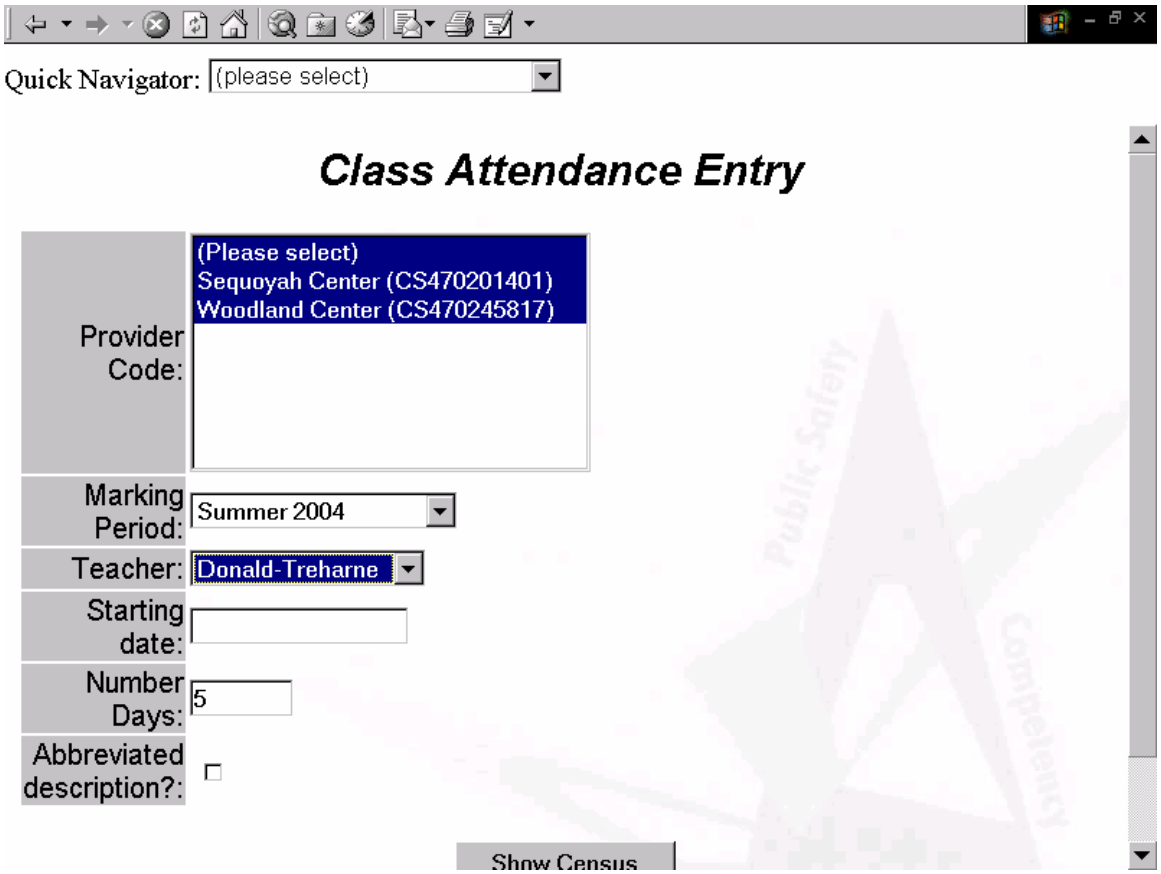
Again, depending on your school enrollment, this process would most likely have been worked out on paper, or by some other paradigm prior to entering this information on to JJIS.

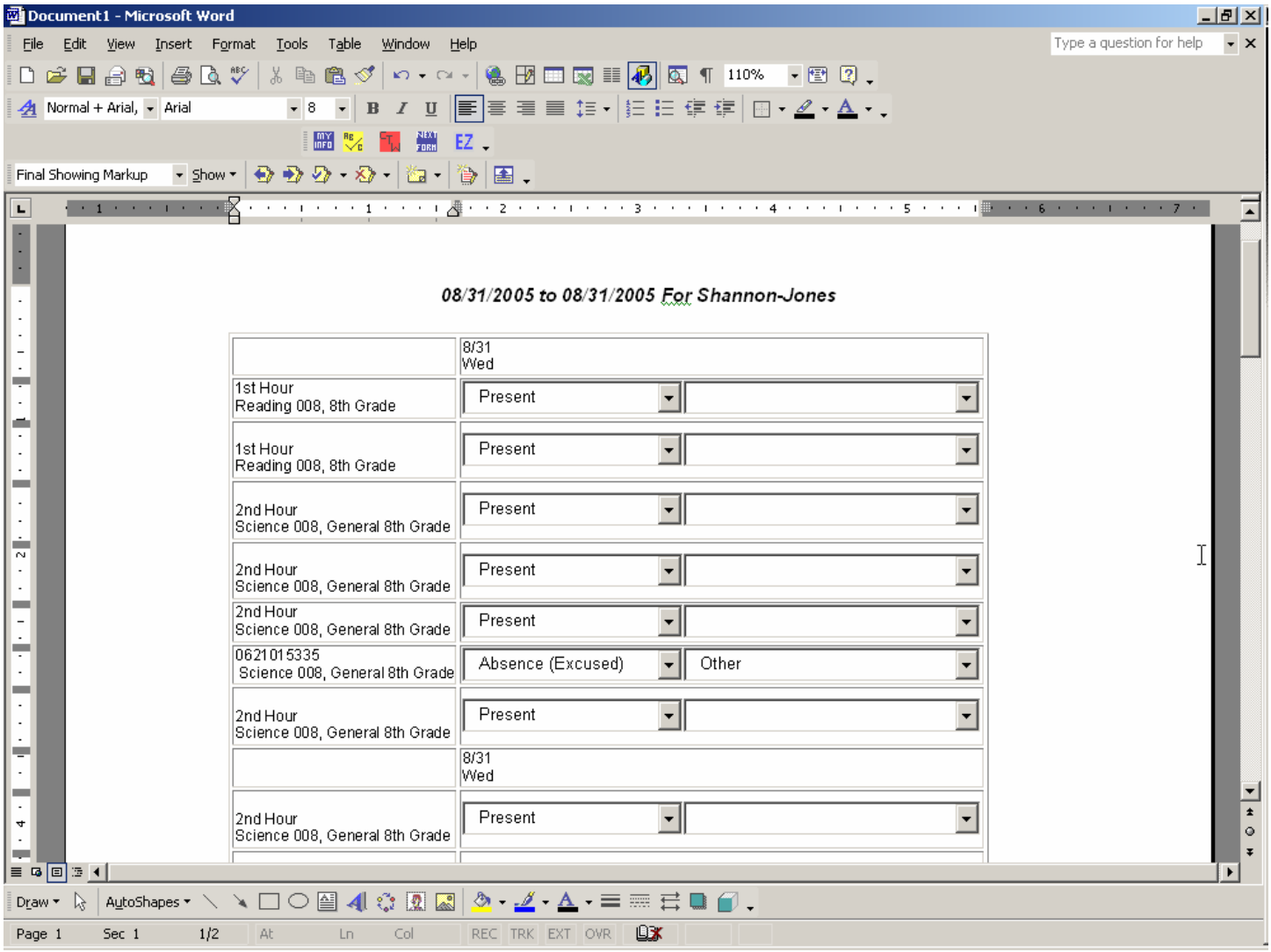
The actual process looks like this:



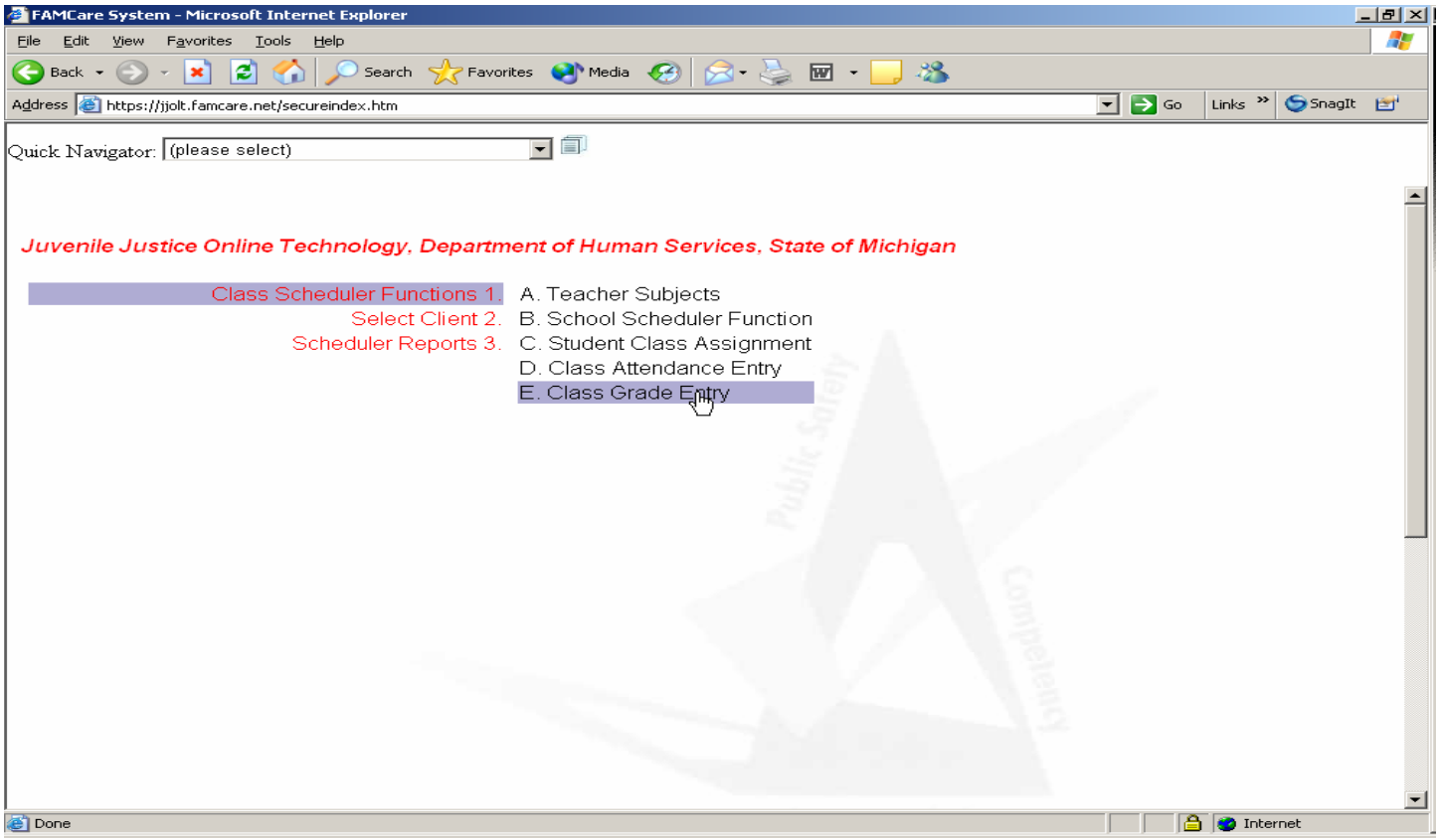
Class Attendance Entry

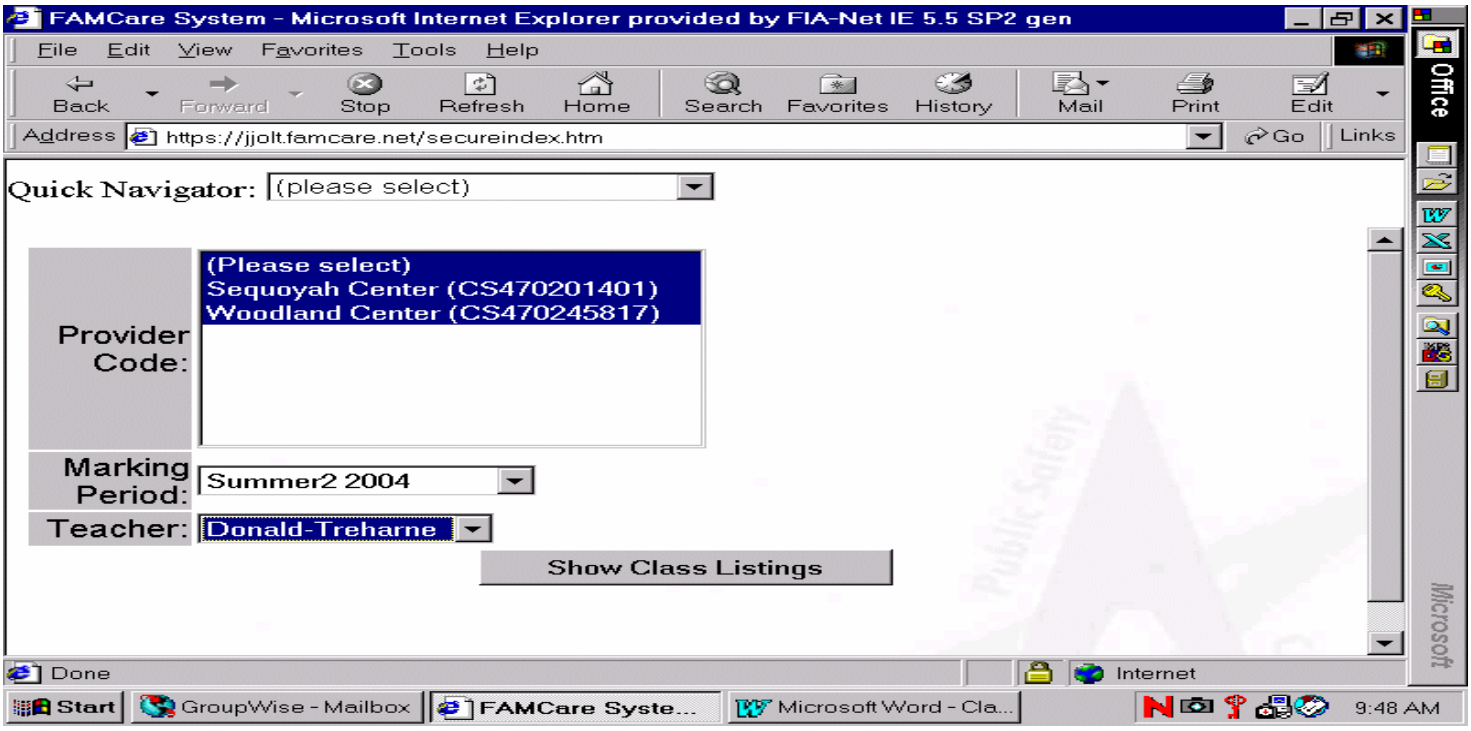



Quick Navigator: (please select)
Class Attendance Entry
Provider Code:
(Please select)
Sequoyah Center (CS470201401)
Woodland Center (CS470245817)
Marking Period:
Summer 2004
Teacher:
Donald-Treharne
Starting date:
Number Days:
5
Abbreviated description?:
Show Census



The student's name will also appear above the class hour and name, located to the left of form.


FAMCare System - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites Media
Address https://jjolt.famcare.net/secureindex.htm
Go Links SnagIt
Quick Navigator: (please select)
Juvenile Justice Online Technology, Department of Human Services, State of Michigan
Class Scheduler Functions 1.
Select Client 2.
Scheduler Reports 3.
A. Teacher Subjects
B. School Scheduler Function
C. Student Class Assignment
D. Class Attendance Entry
E. Class Grade Entry
Done
Internet


FAMCare System - Microsoft Internet Explorer provided by FIA-Net IE 5.5 SP2 gen
File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail Print Edit
Address https://jjolt.famcare.net/secureindex.htm
Go Links
Quick Navigator: (please select)
Provider Code:
(Please select)
Sequoyah Center (CS470201401)
Woodland Center (CS470245817)
Marking Period:
Summer2 2004
Teacher:
Donald-Treharne
Show Class Listings
Done
Internet
Start
GroupWise - Mailbox
FAMCare Syste...
Microsoft Word - Cla...
9:48 AM

General Subject	Course	Course Teacher	Grade	Credit	Hours
Janie JJIS (Woodland Center)					
Social Studies	Social Studies 105 - U.S. History	Chiquita-Adams	: Select		

Course Comment Codes:

: Select

: Select

: Select

: Select

Report Individual Student Grades

Select Enter Grades - the following screen will appear.

Name:	Janie JJIS	**SSN:**	**XXX-XX-3459**
DHS #	**W2345678W**	**Date of Birth:**	**1/18/1989**
JJIS #:	062314598	**Age:**	**16 years, 0 months**
Admission Date:	**7/15/2005**	**Release Date:**	**12/31/2009**

Choose School Type:	◉ **Public/Private Facility** ○ **Public School**
Public/Private Facility:	Woodland Center

Contact Person:	Osborne, Gail
Marking Period:	(Please select) Select Marking Period, or Enter Dates
	Begin Date: 10/31/2005 **End Date:** 12/22/2005

Enter the Grade Information, leave unused sections blank

eral Subject	Course	Course Teacher	Grade	Credit	Hours
e 1					
ase select)	Select General Subject	(Please select)	: Select		

Course Comment Codes:

: Select

: Select

: Select

: Select

To enter grades:

1. Choose School Type: Public/Private Facility or Public School
2. To select facility or public school from drop-down:
   - Type the first letter of facility or school
   - Press the "enter" key and select from drop-down list.
3. To select contact person:
   - Type the first letter of the contact person's first name
   - Press the "enter" key and select contact teacher from drop-down list.

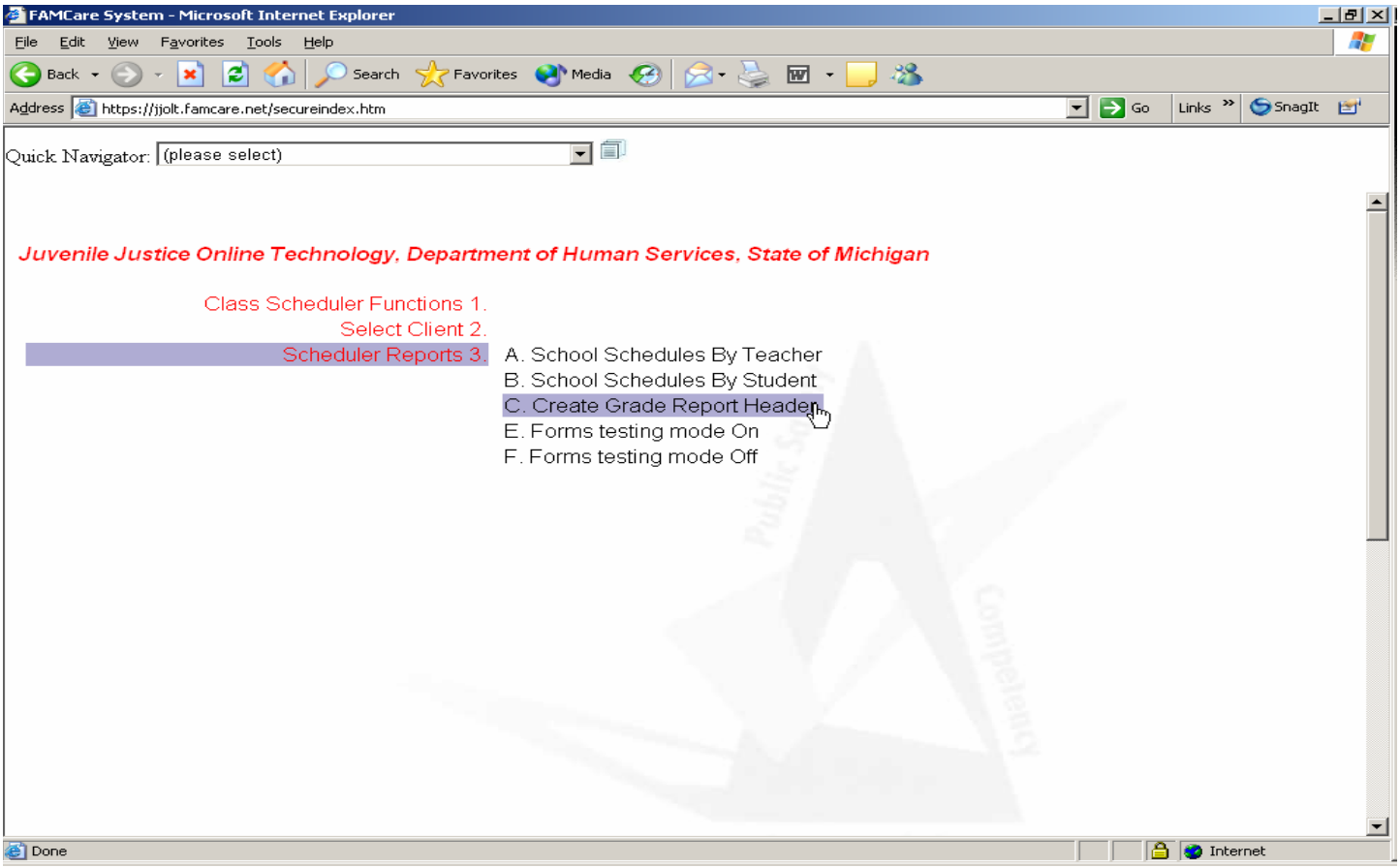
   NOTE: Teacher's name will not appear on drop down list unless a Security Agreement has been completed.
4. Input "Marking Period" beginning and end dates.
5. Select General Subject i.e., Lang. Arts, Math, etc.
6. Select the course name from drop down list. The Course Code/Name should coordinate with the general subject matter selected.
7. To select the course teacher:

   For Public/Private Facilities
   - Type the first letter of the course teacher's last name press "enter". Select course teacher from drop-down list.

   For Public Schools
   - Type the course teacher's name, last name first.
8. Select grade from drop down selection.
9. Input credits earned. Credits earned cannot exceed total credits allotted for course.
10. Optional – Enter total hours student participated in subject.
11. Select Course Comment Codes – you can select up to four different comments.
12. Enter Next Subject – Repeat Steps 5 –11. You can enter 1 – 10 different subjects.
13. Sign using your password.
    - Click on the "Save" button.
    - Save Confirmation Screen press "Click here to continue"

Create Grade Report Header

School and/or Center Secretary input information at the beginning or end of marking period for Public/Private facilities with on-ground school.



1. From the Quick Navigator
   - Select Class Scheduler (the above screen will appear)

2. Select #3C Create Grade Report Header

3. Select Create New Form (the screen on the next page will appear).

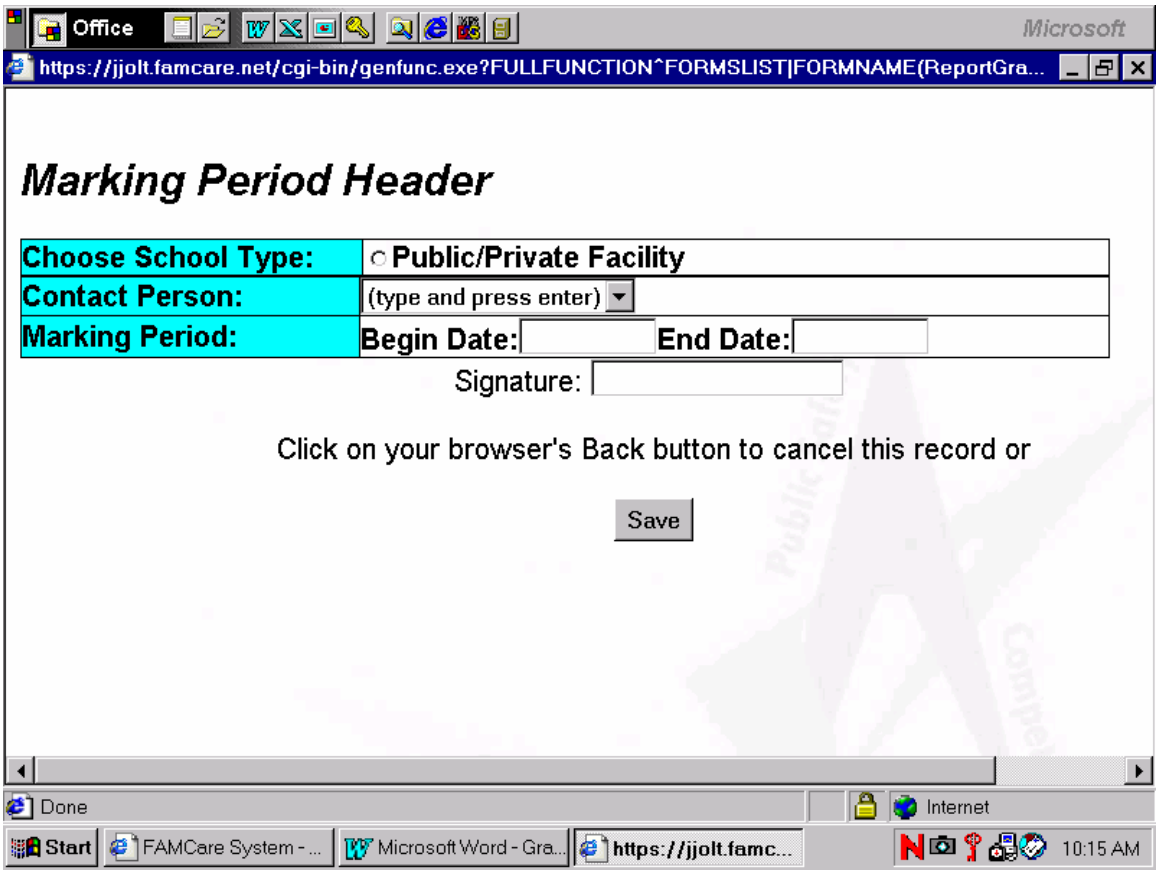
4. Choose School Type: Public/Private Facility

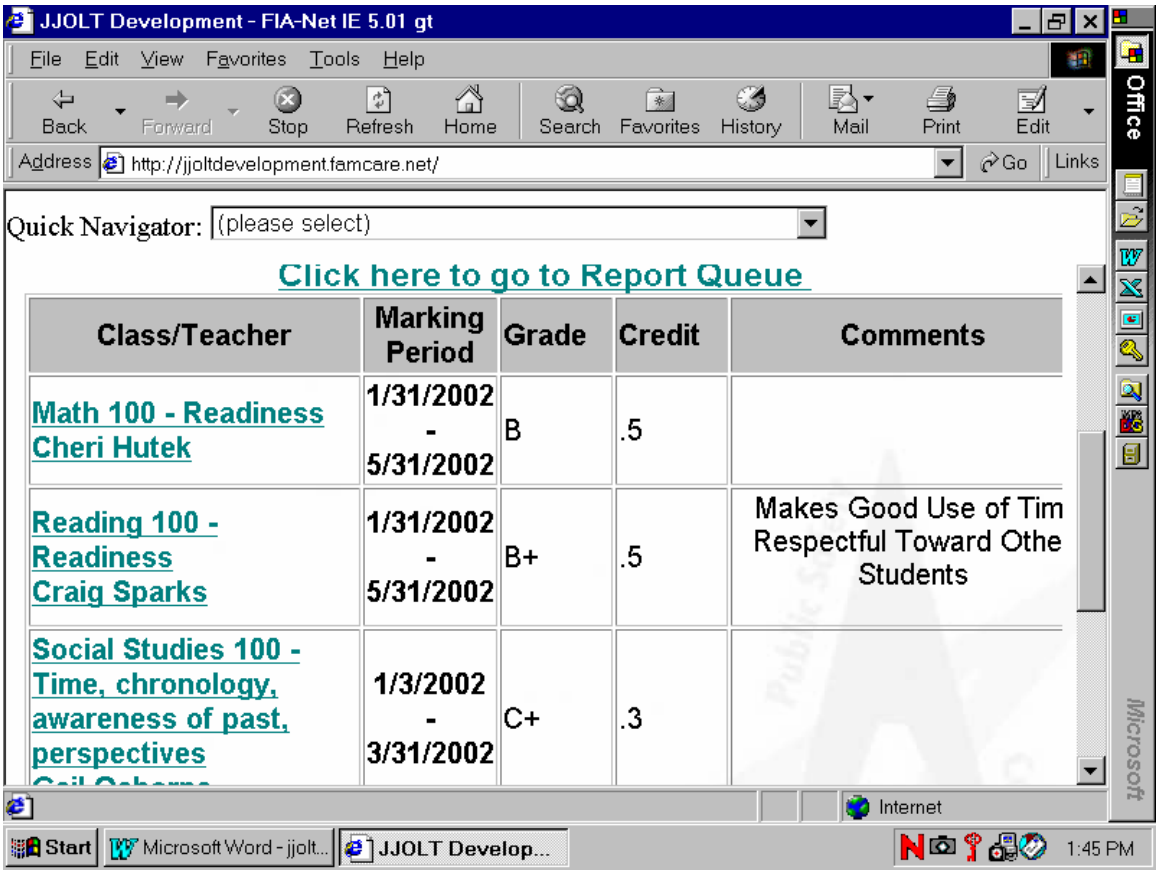
5. To select facility from drop-down list:
   - Type the first two letters of your facility.
   - Press the "enter" key and using down arrow select your facility from drop-down list.
6. To select contact person:
   - Type the first two letters of the contact person's last name.
   - Press the "enter" key and select contact person from drop-down list.

7. Input "Marking Period" beginning and end dates.

8. Click on the “Save” button.

9. Save Confirmation Screen press “Click here to continue.”



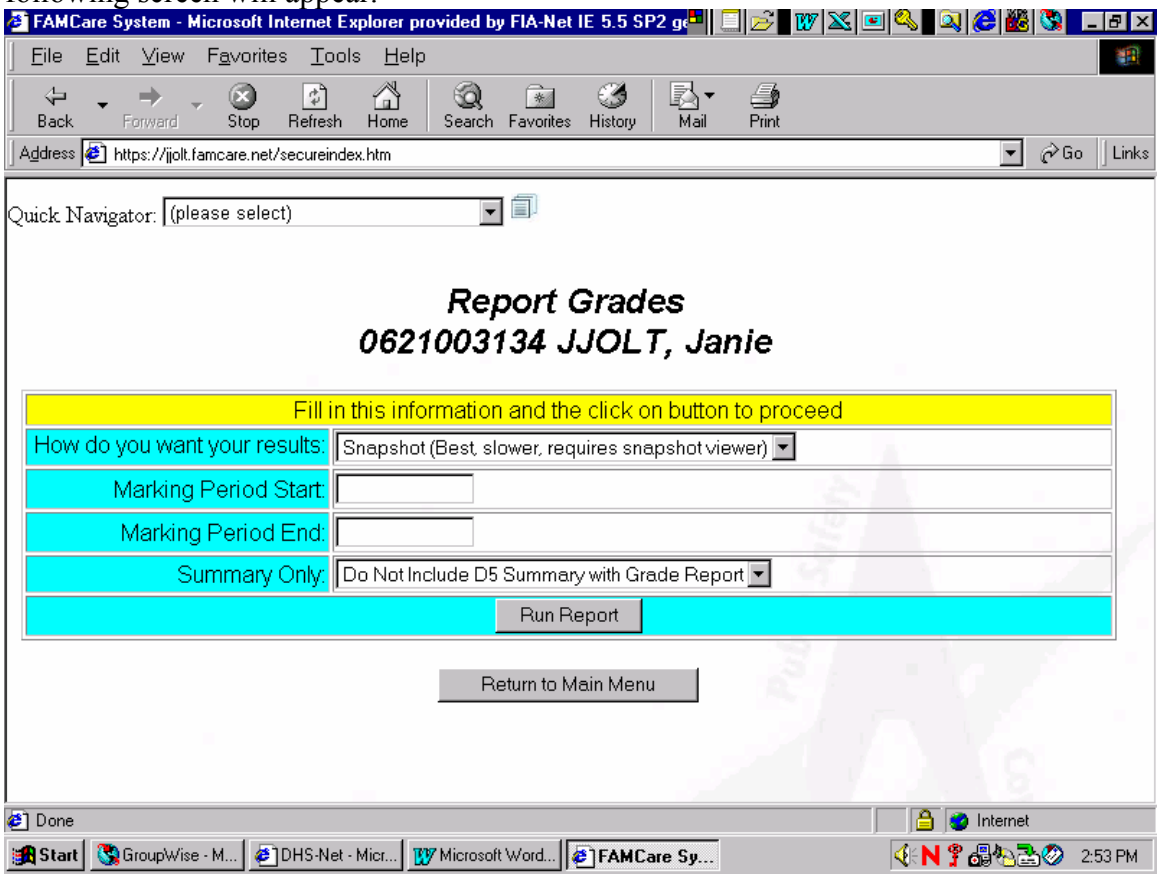


To Edit Grades

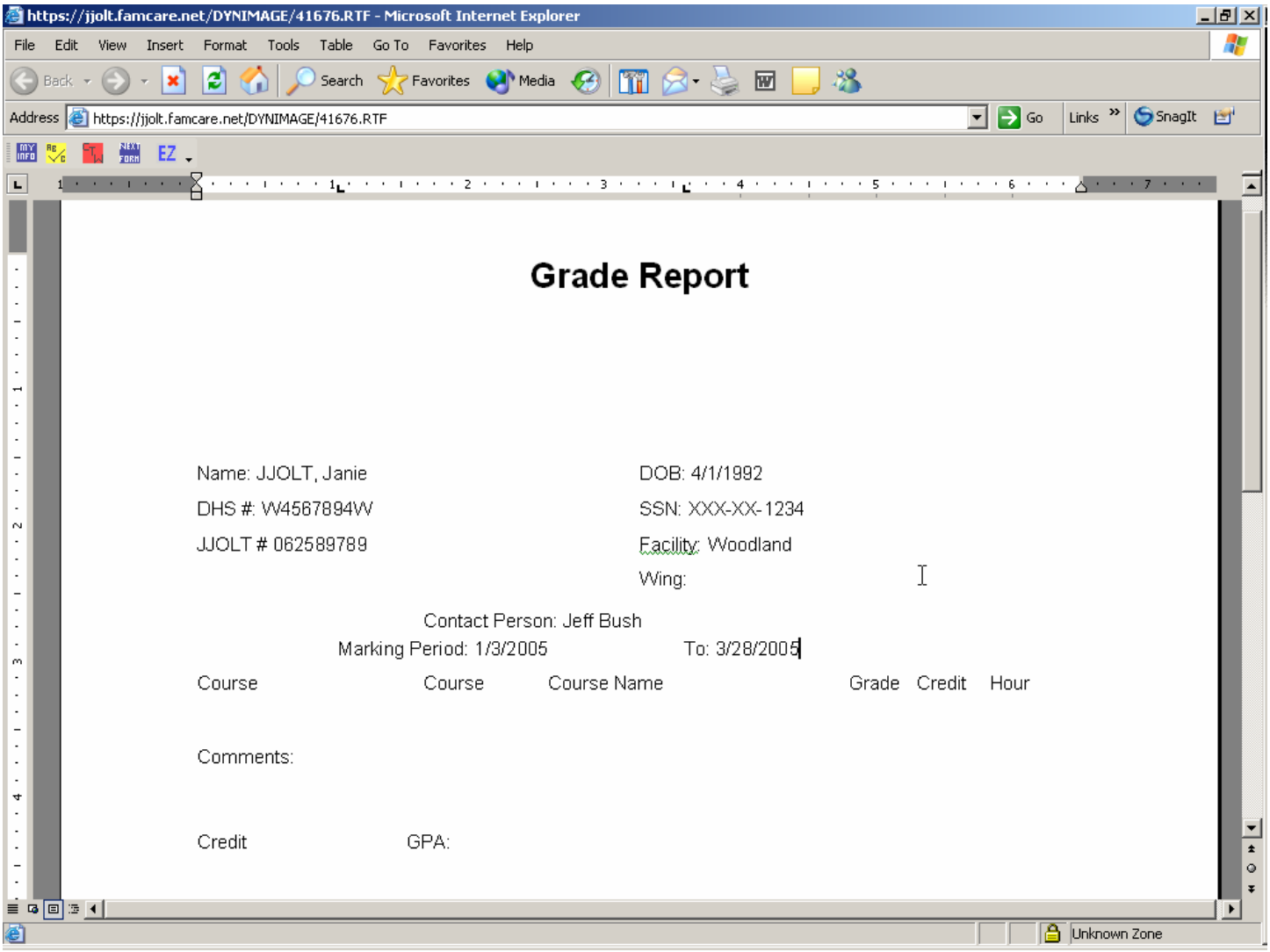
1. Select Class/Teacher – click on green hyperlink
2. Edit grade, credit etc.
3. Save
4. Close this screen and refresh summary

To print Grade Report:

You can print the report from 11G or 11A Grade Report/Transcript Section - select "Print Grade Report". The following screen will appear.



1. Type in start date of marking period.
2. Type in the end date of marking period.
3. Click "Run Report"
4. Report Submit Confirmation screen will appear choose "Click here to View Report Queue". The first report is the report you requested.
5. Select "View Report" the Grade Report for the period selected will appear.
6. Select picture of printer in the lower left-hand corner of screen to print.

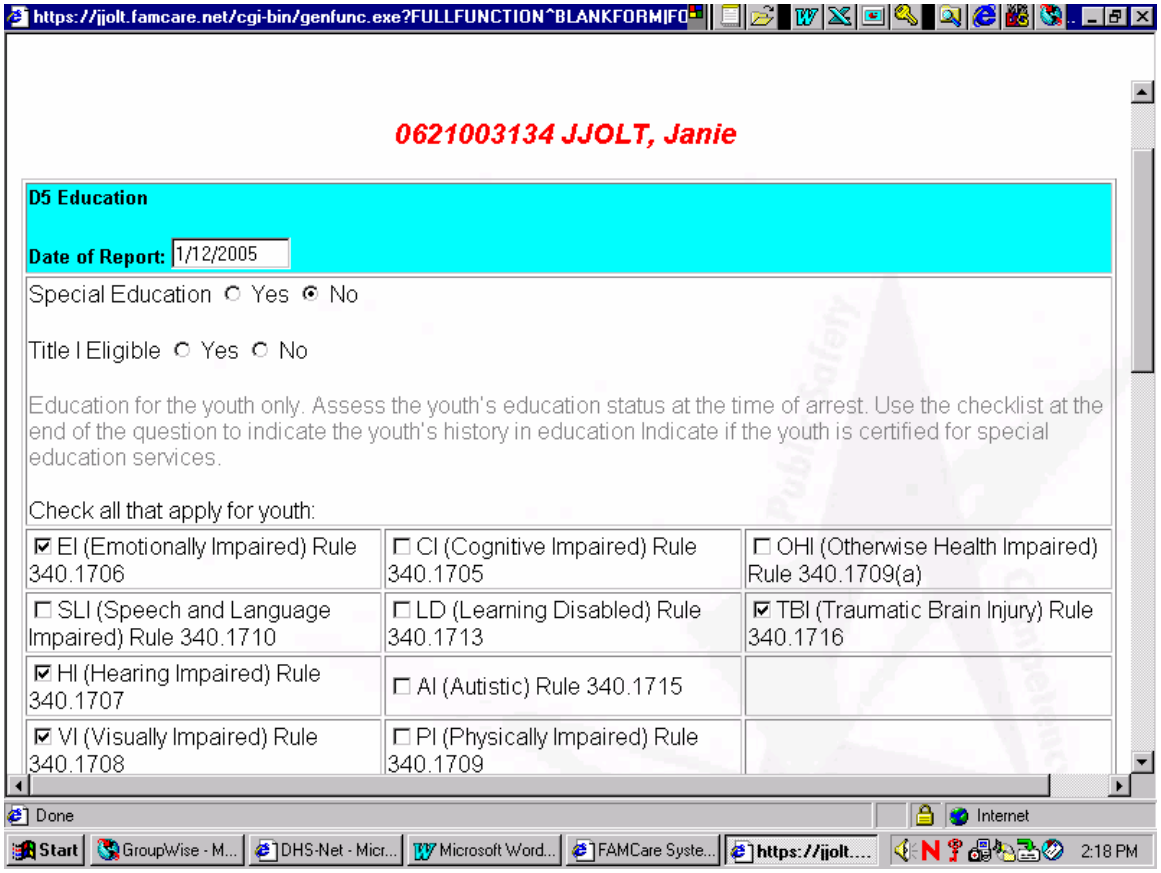

https://jjolt.famcare.net/DYNIMAGE/41676.RTF - Microsoft Internet Explorer
File Edit View Insert Format Tools Table Go To Favorites Help
Back Search Favorites Media
Address https://jjolt.famcare.net/DYNIMAGE/41676.RTF
Go Links SnagIt
Grade Report
Name: JJOLT, Janie
DOB: 4/1/1992
DHS #: W4567894W
SSN: XXX-XX-1234
JJOLT # 062589789
Facility: Woodland
Wing:
Contact Person: Jeff Bush
Marking Period: 1/3/2005
To: 3/28/2005
Course
Course
Course Name
Grade
Credit
Hour
Comments:
Credit
GPA:
Unknown Zone

D5 Education Information

This information is linked to the Strength and Needs report that is completed by treatment worker. D5 is the education information to this report that the Education Department provides input to the Initial, Update and Release Treatment Plans. The Education Department can maintain their separate report and update the treatment worker reports.

D5 – Education – Initial Report:

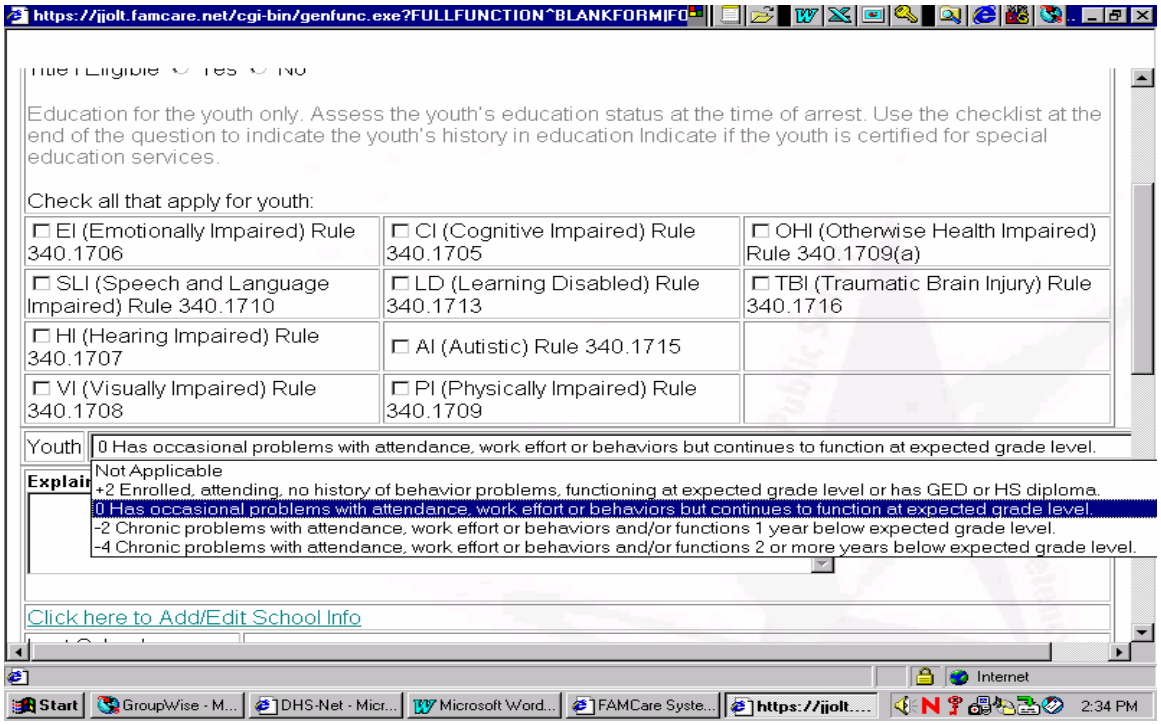
1. Go to Education Forms – select D5 Education Information
2. Select Create New Form
3. Date of Report – The system will auto-fill with current date. **(Note: Use current date or enter date of Strengths and Need's Report. D5 Education Information will update the Strength and Need report with the last updated D5 report.)**



Input Education information

1. Special Ed. – click mouse to select yes or no. If "Yes" below select all eligible disabilities that apply to student.
2. Title I Eligible – click mouse to select yes or no, if you do not know if student is eligible leave blank.

3. **Youth** – select appropriate scoring assessment for student using down pick-arrow.



4. Update Last School Attended and Last Grade Completed.
5. Update student behaviors that apply, i.e. GED and date received GED.
6. Input student Goals.
7. If Special Ed. Update IEP Goals.
8. Save and Refresh
9. Using Quick Navigator – go to Forms Menu for your client or logoff JJIS.

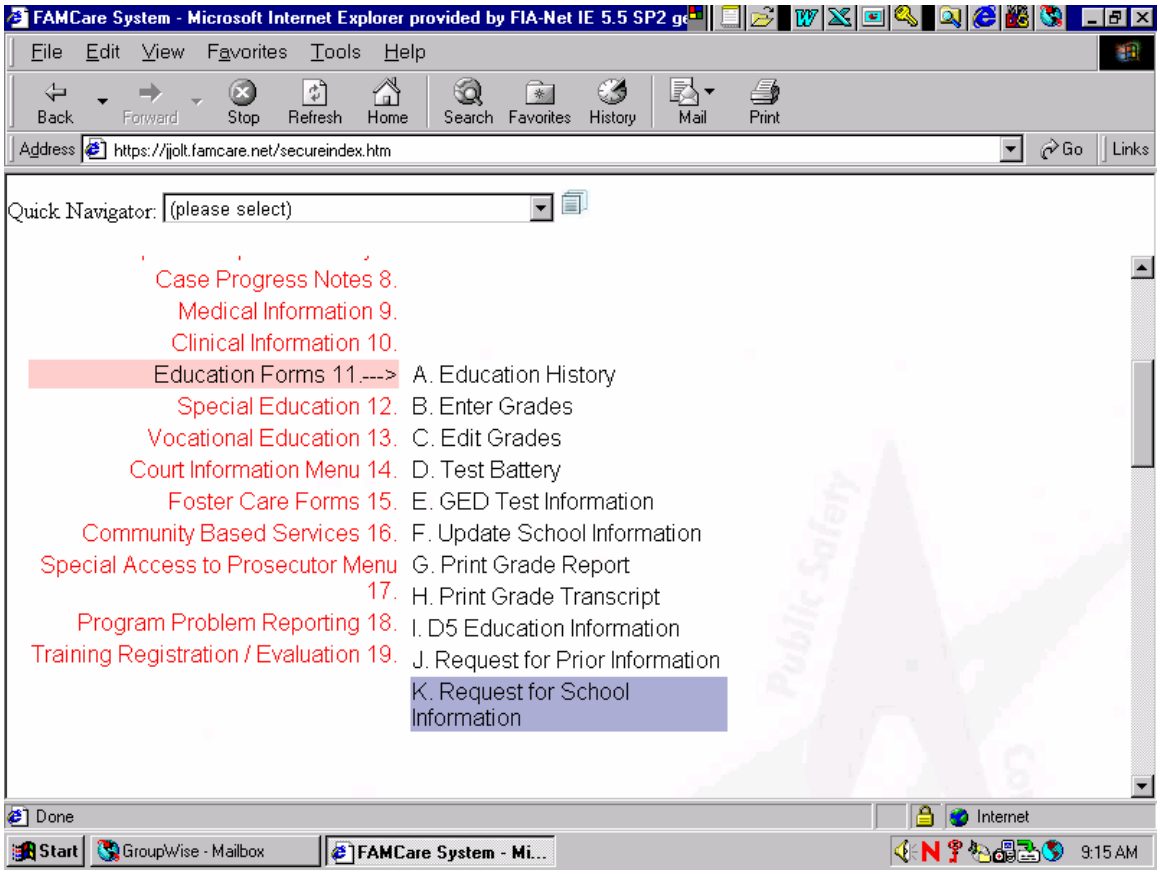
D5 – Education Information – Update/Progress Report

1. Go to Education Forms – select D5 Education Information.
2. Select Copy Existing Form (JJIS will copy last saved D5 report).
3. Date of Report – Enter current date or Strengths and Need's reporting period. **(Note: D5 Education Information will update the Strength and Need report with the last updated D5 report.)**
4. Input Education Information – follow above procedures.

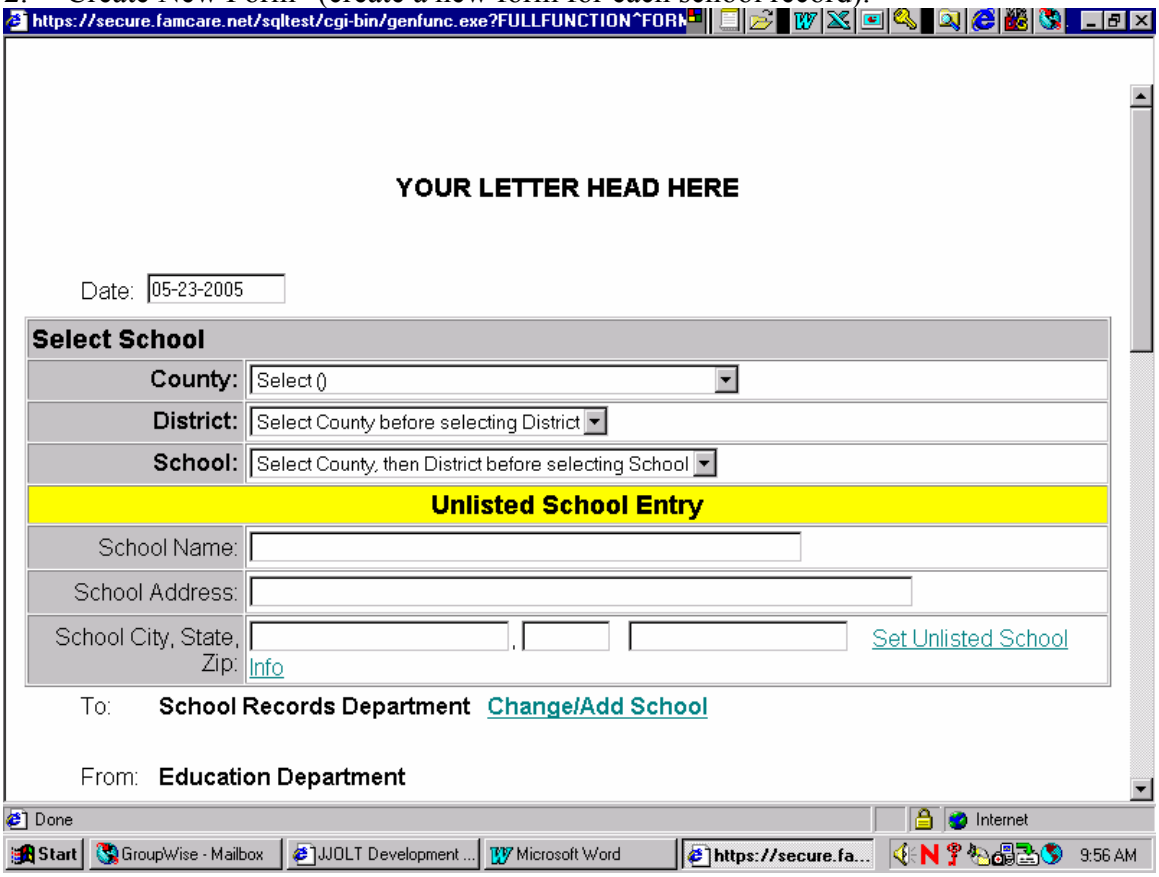
Request School Information

To Request Student's Records from prior schools:

1. Select 11K "Request for School Information"



2. “Create New Form” (create a new form for each school record).

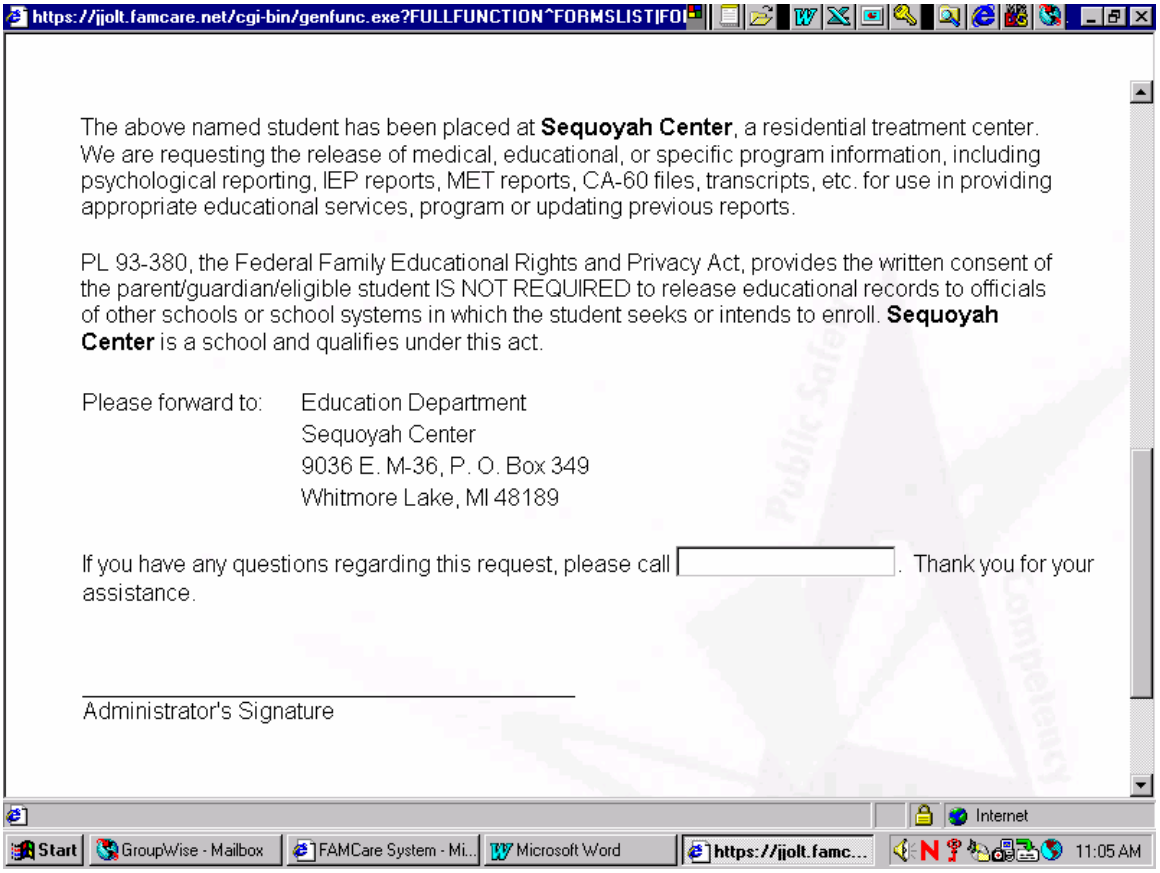


3. Select school “County” ex: Wayne County

4. Select school “District” ex: Detroit Public School District

5. Select “School” ex: Central High School – Detroit

6. The system will populate request form with student current placement information.



7. Type in contact person telephone number.

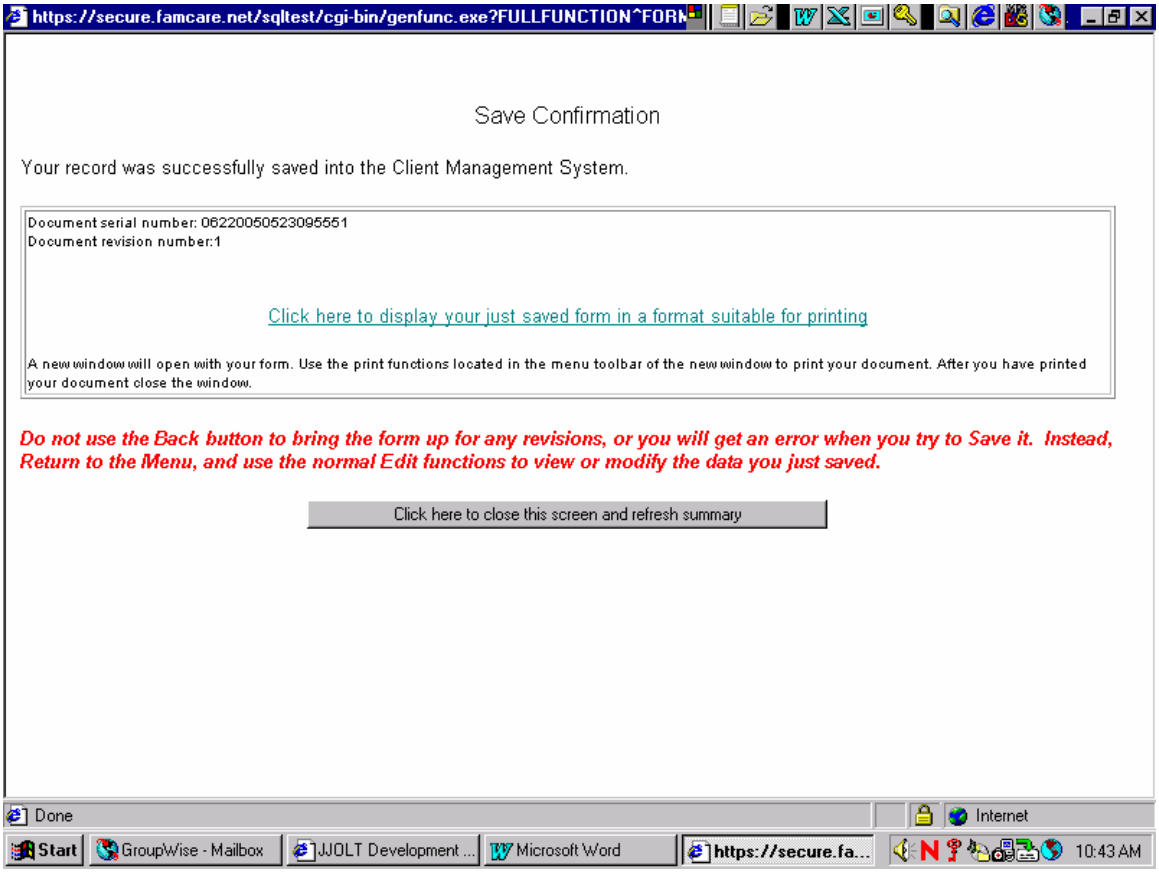
8. Save

To Print on your facility letterhead

1. Select “Click here to display your just saved form in a format suitable for printing”

2. Place letterhead in printer
   NOTE: Depending on the type of printer as to how the letterhead should be placed in printer – ex: Lexmark printer place letterhead face down – letterhead - front of tray.

3. Select “File” – “Print”

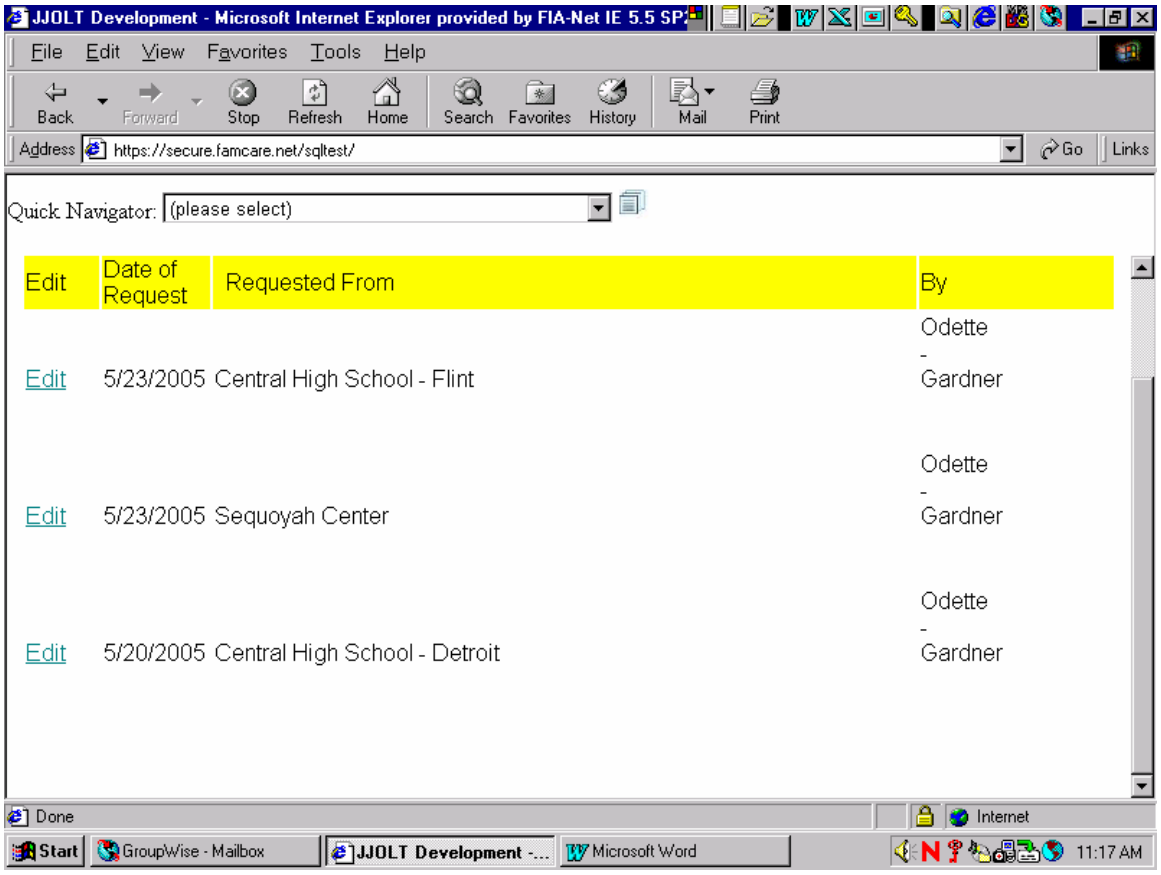


The system will automatically update 11J Request for Prior Information.

Upon receipt of student school records:

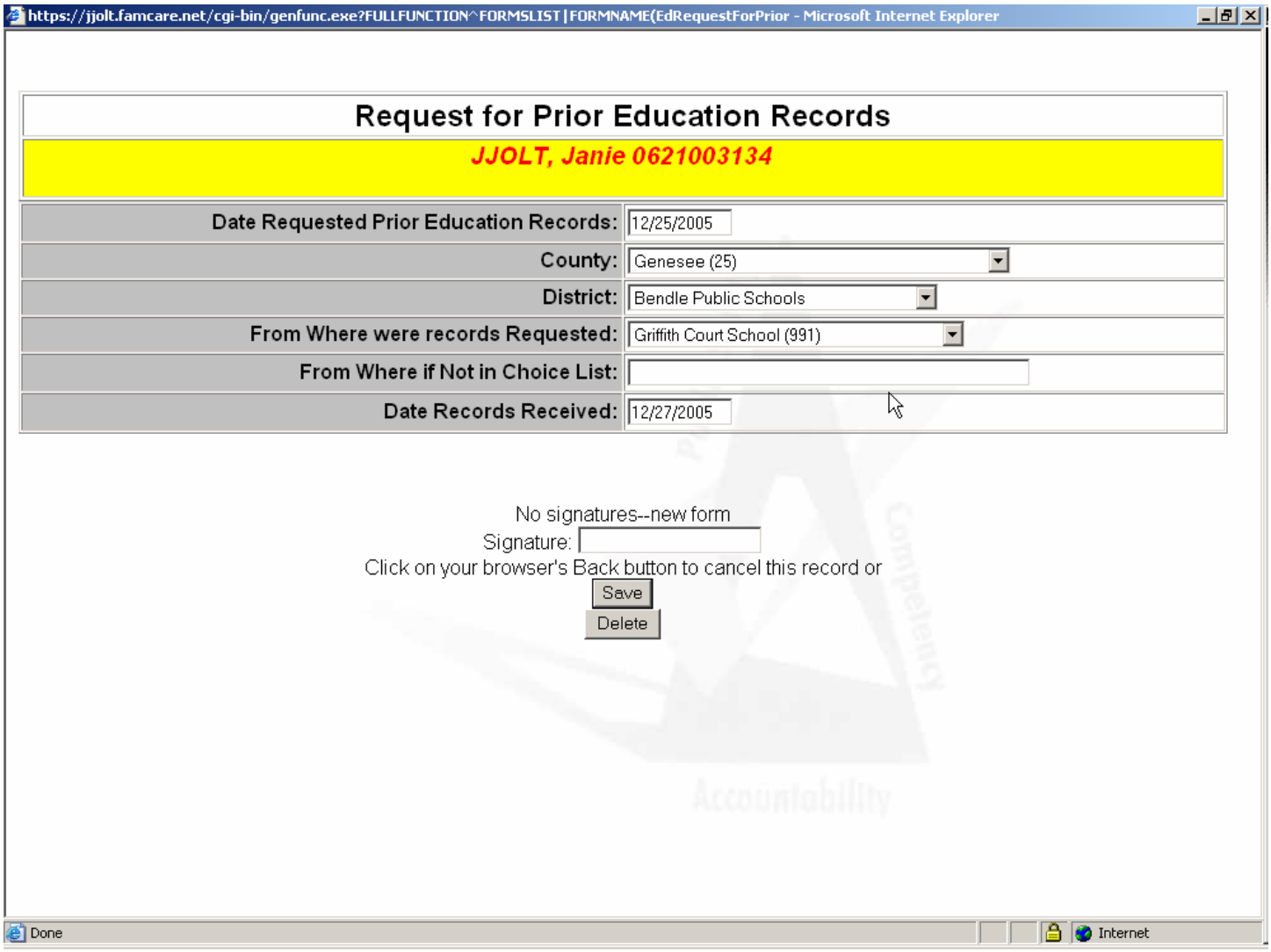
1. Select 11J – Request for Prior Information

2. Edit Request for Prior Information – select "Edit" school received records from. Ex: Edit Central High School – Detroit.



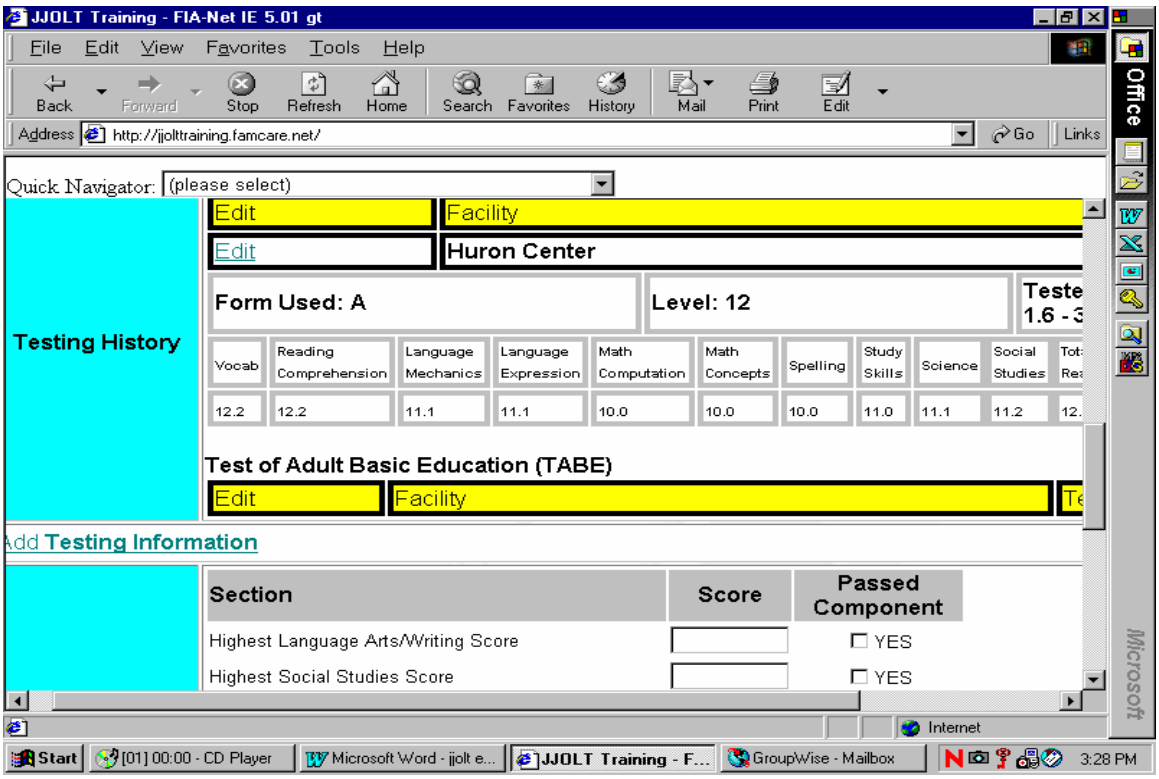
3. Type date records received

4. Save



Testing History

Testing History will display the last's three CAT-5 and TABE testing information.

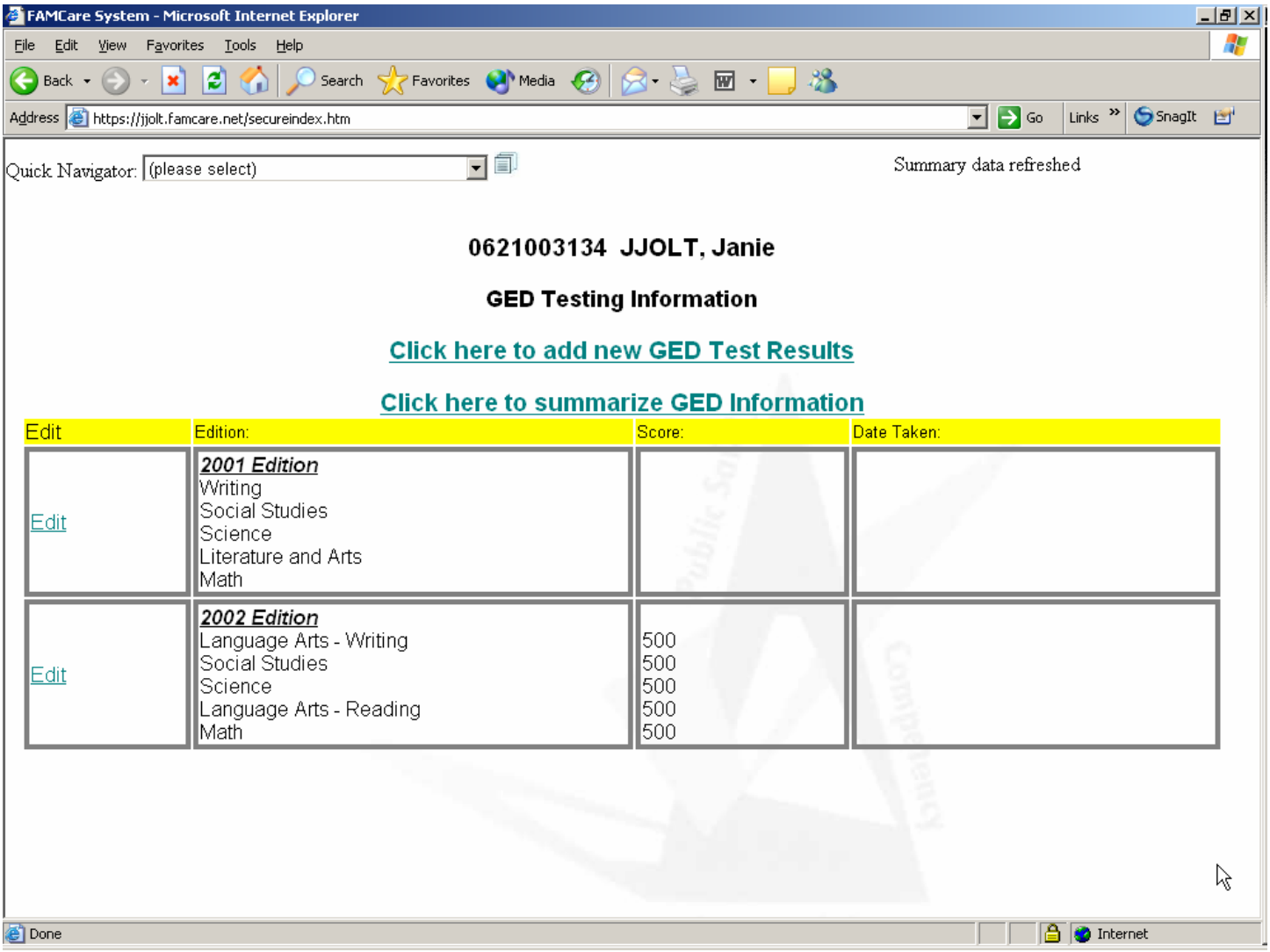


To add Testing Information:

Select 11D Test Battery or from 11A Click on "Add Testing Information" Education Test Battery screen will appear.

1. Select testing form from drop box.
2. Click "Create New Form".
3. Input information required for testing form requested.
4. When data entry is completed, click on the "Save" button.

The Testing Battery Screen will display the history of all testing completed by student. To view a previous test select "Edit" next to the test you wish to view.



GED Testing

Select GED Testing, 11E or from 11A, go to GED Information section "Click here to add GED Test Results" the above screen will appear.

To add new GED Test:

1. Select "Click here to add new GED Test Results".
2. Select GED test Edition from drop down box (prior to 2002). The section for the appropriate edition will appear in Section column.
3. Input "Score" tab to next column.
4. Input "Date Taken" (date the test was taken) tab to next column.
5. Select "Official Test Center from drop down box.

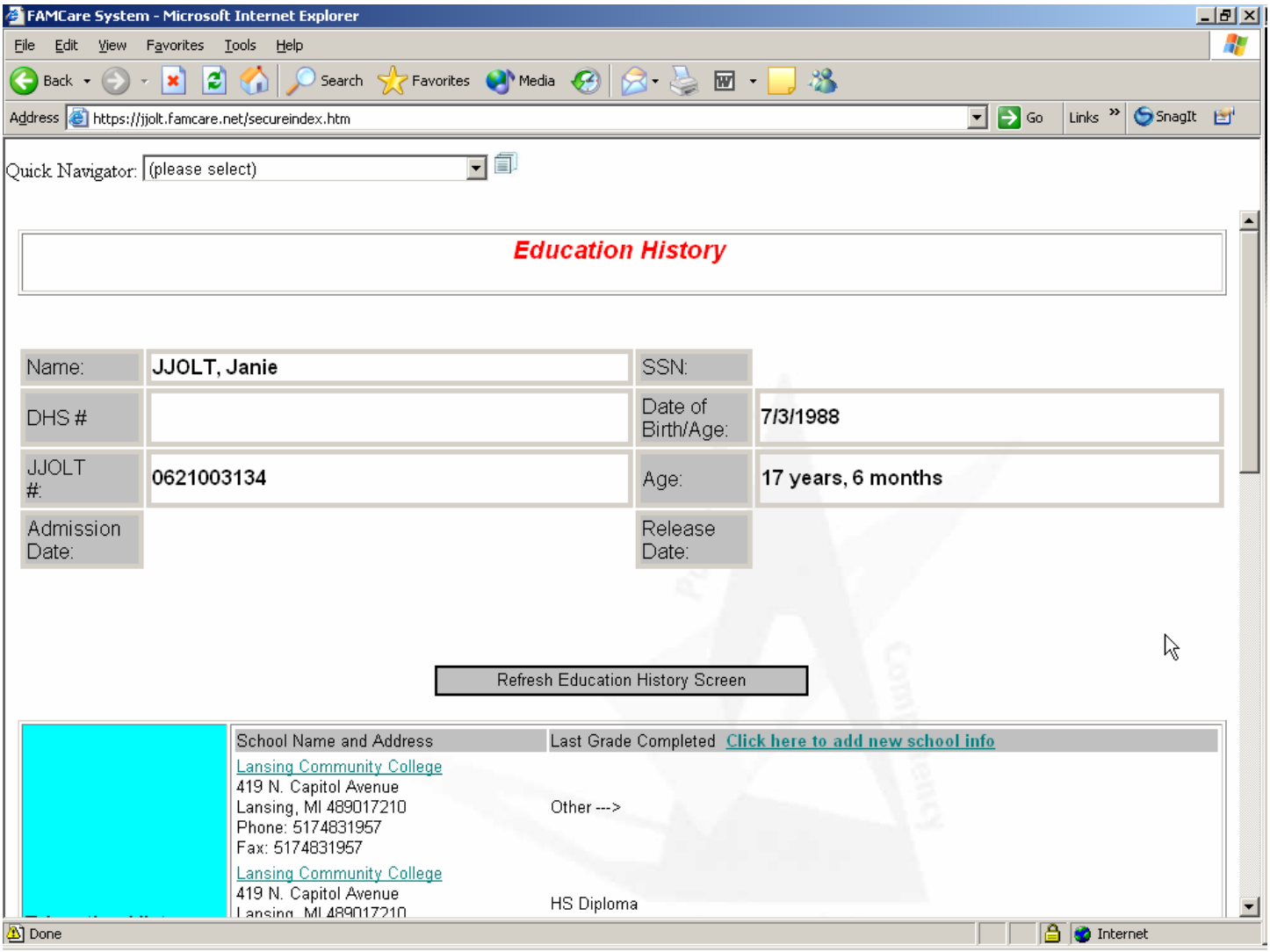
Repeat above until all scores of sections completed have been entered.

6. Optional Comment box – type comments. Spell check is available. (ABC √ bottom next to comment box. First time use of spell check see Spell Check installation instructions.)
7. Save – test score will appear on 11A – Education History GED information section.

Education History – 11A

Prior to entering GED scores warning will appear on screen "This client has no GED test saved and therefore no processing can be done on this screen." Press "OK" to clear screen.

Identifying information is pre-populated. **Education History** – This information is pre-populated from the Intake Summary 1A.



From the Education History summary you can link to all the education sub-forms to update information and print.

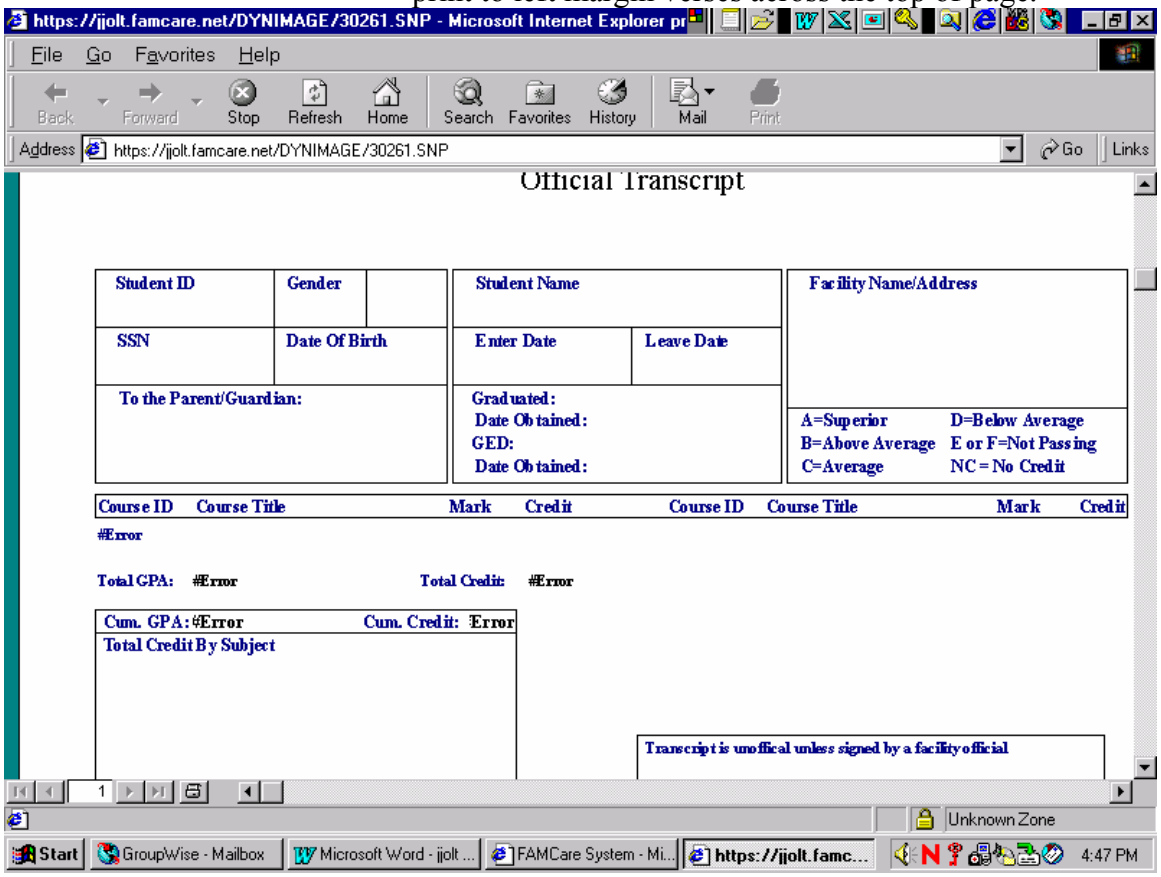
Individual Transcripts

To Print Grade Transcript:
You can print the report from 11H or 11A Grade Report/Transcript Section selects "Print Grade Transcript."

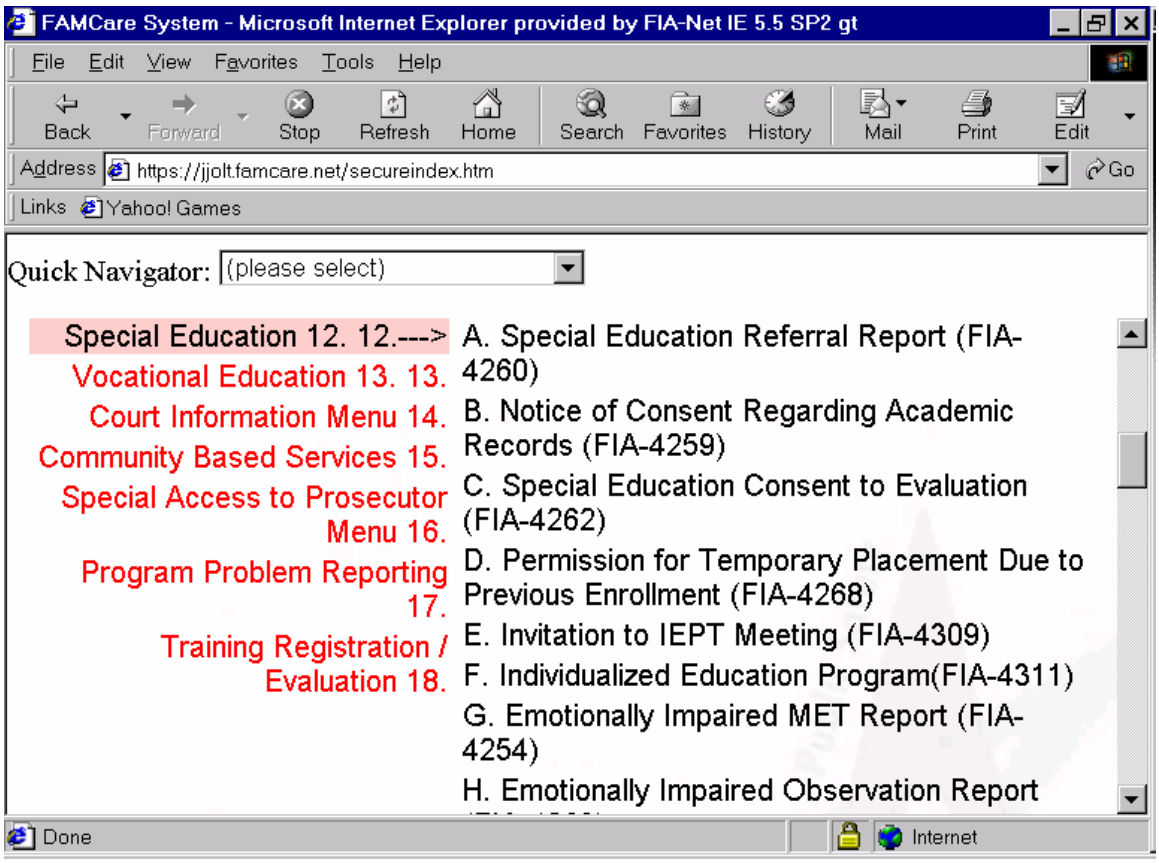
1. Two options -
   - Select Current Data (real-time includes all recently saved data)
   - Select Nightly Pre-Compiled Data (all data save by 12 a.m.) runs faster then above selection.

2. Batch Transcripts
   - Quick Navigators – Select Custom Reports
   - Select Education Reports – 6J Batch Printing of Client Transcripts
   - System will default to print All Client Transcripts
   - To select specific client records right click mouse on student's name
   - To deselect – right click on student's name highlighted in blue
   - Once you have selected all desired students records – select Run Report
   - Report will be the first report in print queue.

NOTE: Batch printing of transcripts has different look then individual transcripts – heading information will print to left margin verses across the top of page.



SPECIAL EDUCATION FORMS



Complete all special education forms using Michigan State Board of Education Special Education guidelines. Special Education forms available on JJIS:

- Special Education Referral Report DHS-4260
- Notice of Consent DHS-4259
- Special Education Consent to Evaluation DHS-4262
- Permission for Temporary Placement Due to Previous Enrollment DHS-4268
- Invitation to IEPT Meeting DHS-4309
- Individualized Education Program (IEP) DHS-4311
- Emotionally Impaired MET Report (EI) DHS-4254
- Emotionally Impaired Observation Report (DHS-4263)
- Learning Disabled MET Report (LD) DHS-4306
- Learning Disable Observation Report DHS-4261
- Cognitive Impairment (CI) MET Report
- Traumatic Brain Injury (TBI) MET Report DHS-4272
- Hearing Impairment (HI) MET Report DHS-4271
- Speech and Language Impairment (SLI) MET Report DHS-4256
- Visually Impaired MET (VI)Report DHS-4275
- Physical Impaired MET (PI) Report DHS-4273
- Other Health Impairment MET Report DHS-4270

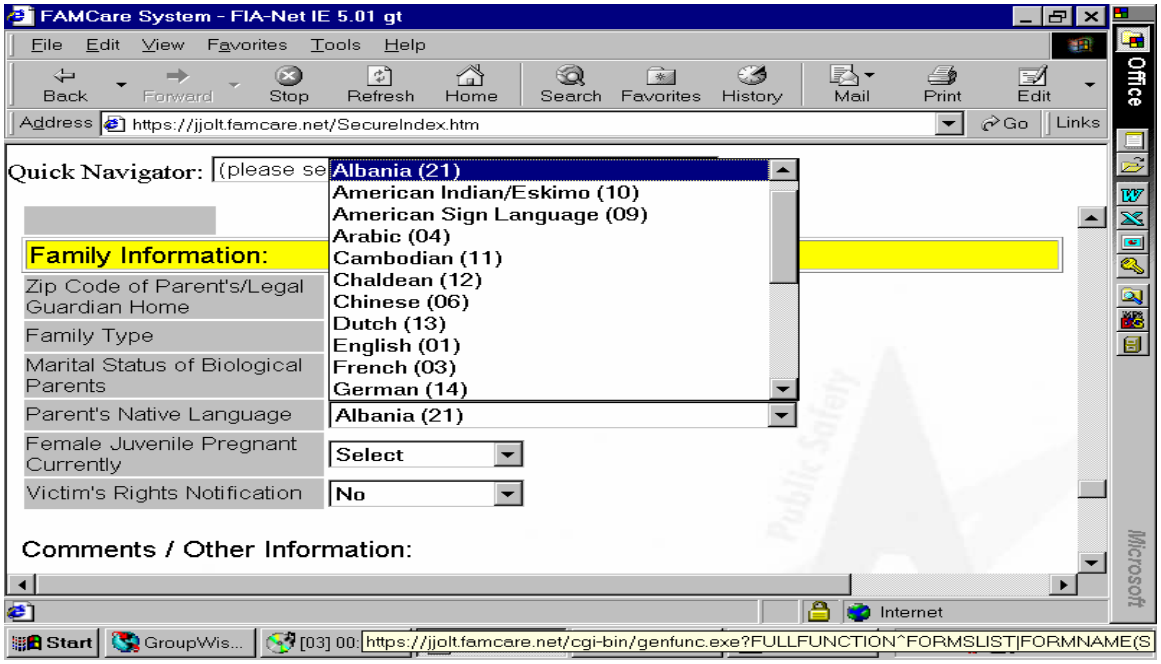
- Evaluation Review DHS 4274
- Autism Impairment (AI) MET Report DHS-4253

Special Education Referral Report (DHS-4260)

Special Education Referral DHS-4260 must be completed within 30 days of admission.

1. Indicate the "Purpose of Report" (right) click your "mouse" once to select the appropriate report.
2. "Date of Referral" will auto-fill with today's date. To change date type appropriate date.
3. "Native Language of Parent(s) will auto-fill from Intake form (1A) (if information is available) or type parent(s) native language.

NOTE: By inputting the parent's native language into the Intake form (1A) will allow the system to automatically populate parent native language wherever it is needed.



- From Client's Forms Menu – Select Intake (1A) Client Intake/Summary.
- Click "green hyper-link" for Family Information.
- Select "Parent's Native Language" from drop down selection.
- Scroll to bottom of page and save change.

1. Complete Special Education Referral DHS-4260 form using special education guidelines, select the appropriate categories and complete comment sections.

NOTE:

Spell Check

To prepare your computer for spell check:

- Go to the task bar for the Internet and click on Tools;
- Click on Internet Options;
- Click on Security;
- Click on Internet;
- Click on Custom Levels;
- Click on the Radial button that says "Initialize and script Active X to make safe," click OK click Yes when it asks "Are You Sure?"

This will never have to be done again.

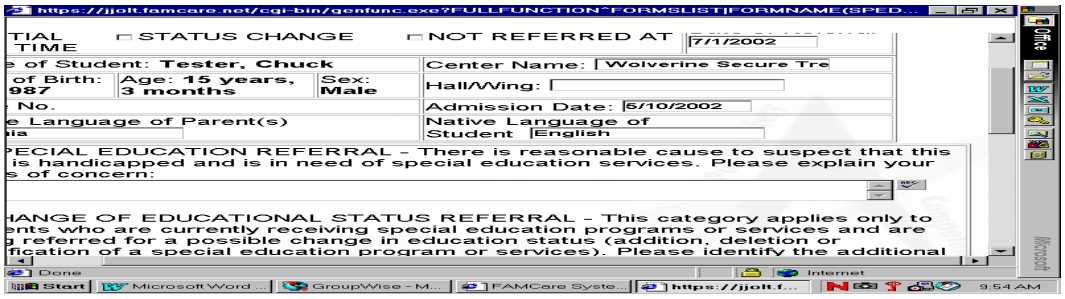
To use spell check:

- Next to each text box there is a spell check button (ABC √).
- Select spell check button to check spelling of text for each text box.

Notify via E-mail – Use e-mail notification to notify form's distribution list, i.e. Central Office (e-mail address DHS-CO-SpEd@Michigan.gov)

- Right click your mouse to select “Notify via E-mail”
- Type e-mail address ex: DHS-CO-SpSd@Michigan.gov

6. Save
7. To Print
   - “Click here to display your saved form in a format suitable for printing.”
   - Select File
   - Print
   - Close screen – return you to Save Confirmation screen, “Click here to close this screen and refresh summary.”



Notice of Consent Regarding Academic Records (DHS-4259)

If youth referred for services, Notice of Consent Evaluate (DHS-4259) along with Notice of Consent (DHS-4259), must be sent to parent/guardian (or youth if 18 years old) within 10 calendar days.

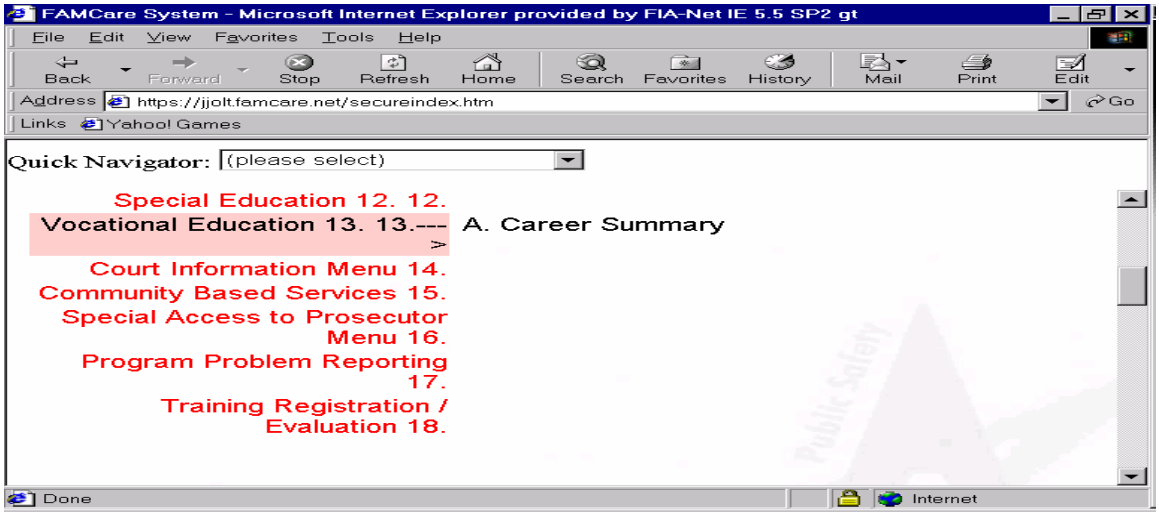
Note: If parent have any kind of restriction their name and address will not show as contact – you must input the appropriate guardian information.

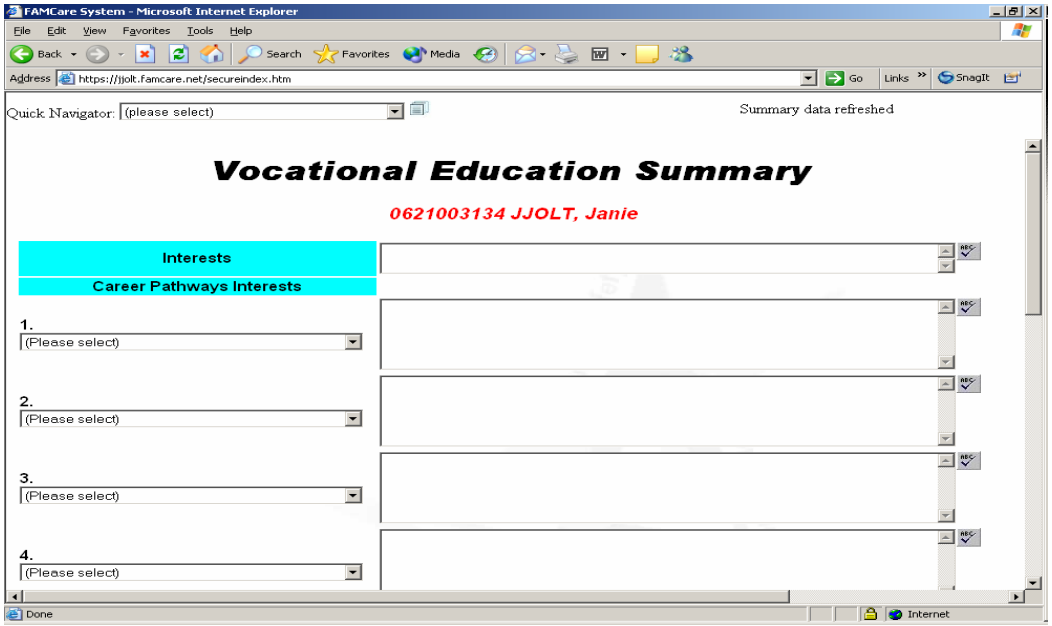
IEP

IEP must be held within 30 school days of date of parent/guardian/youth consent.

Once IEP is held, completed paperwork needs to be sent to Central Office, JJS/CMO, parent/guardian, etc. within 7 calendar days.

Vocational Education





Career Summary

1. To complete student's Interests type in text box.

NOTE: Next to each text box there is a spell check button (ABC√). Select spell check button to check spelling of text for each text box.

2. Select Career Pathways Interests from drop-down list. (You can make up to six different selections.)
3. Input information in text boxes for:
   - Lifestyle Preferences
   - Workplace Skills
   - Achievements, Awards, Certificates
   - Areas Needing Improvement
   - Careers Explored
   - Short Term Goals
   - Long Term Goals
4. Input High School Courses to prepare for this career plan.
   - Freshman
   - Sophomore
   - Junior
   - Senior
5. When data entry is completed, click on the "Save" button.

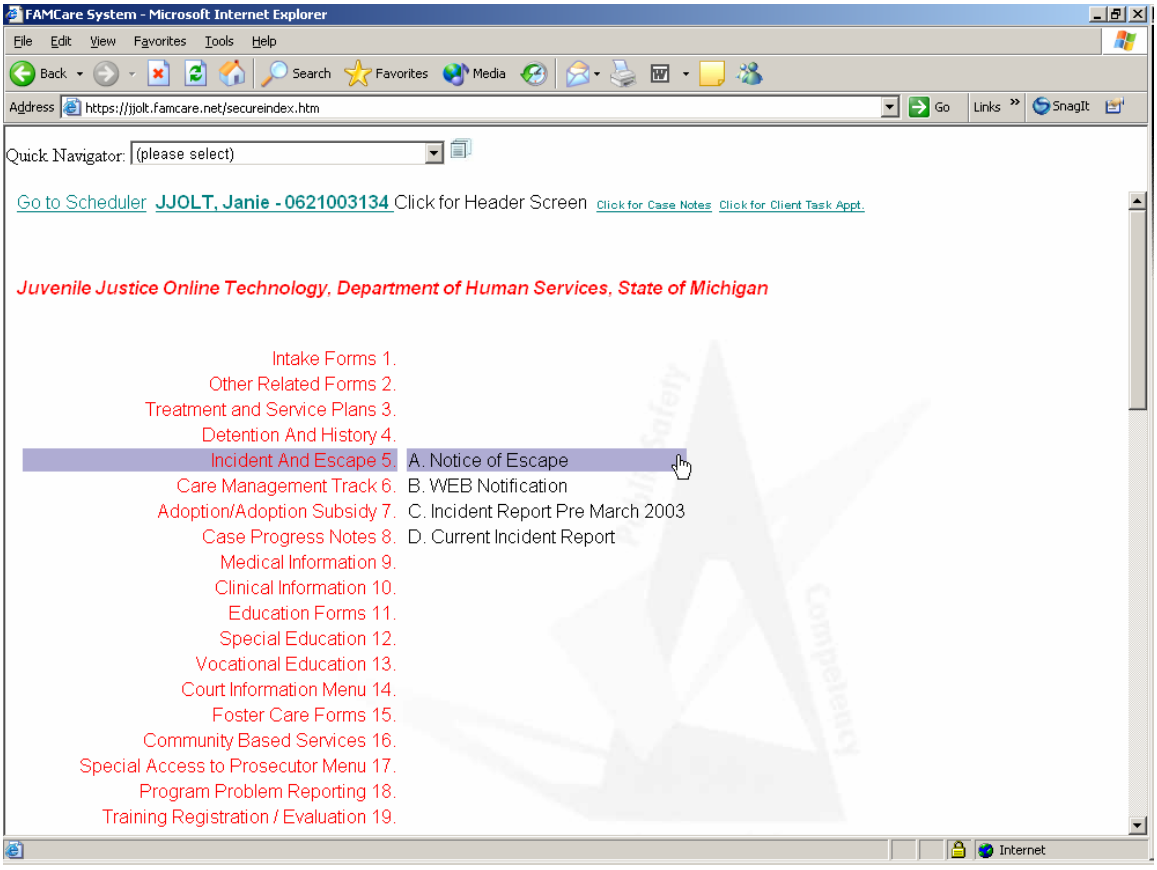
Logoff JJIS FamCare

To Log-Off System:

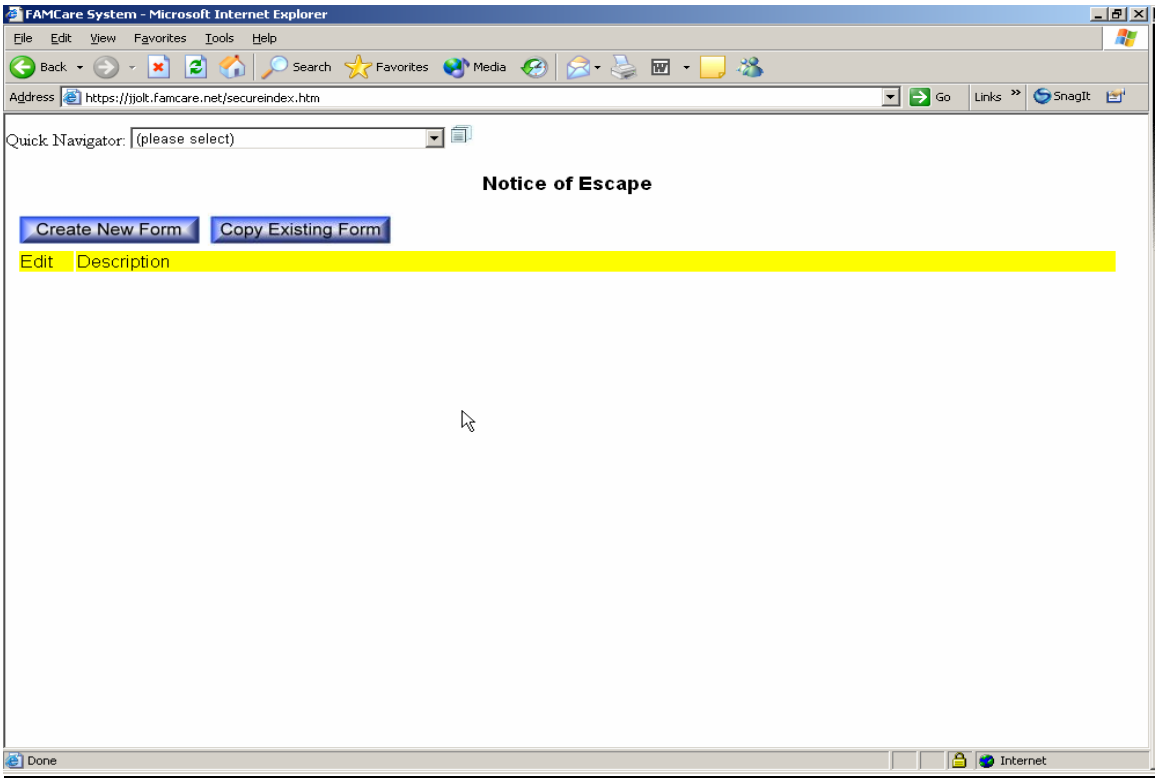
1. At the top of main screen is a "Quick Navigator" bar. Clicking on the field produces a small drop-down menu of the different areas for which the user has been granted access.

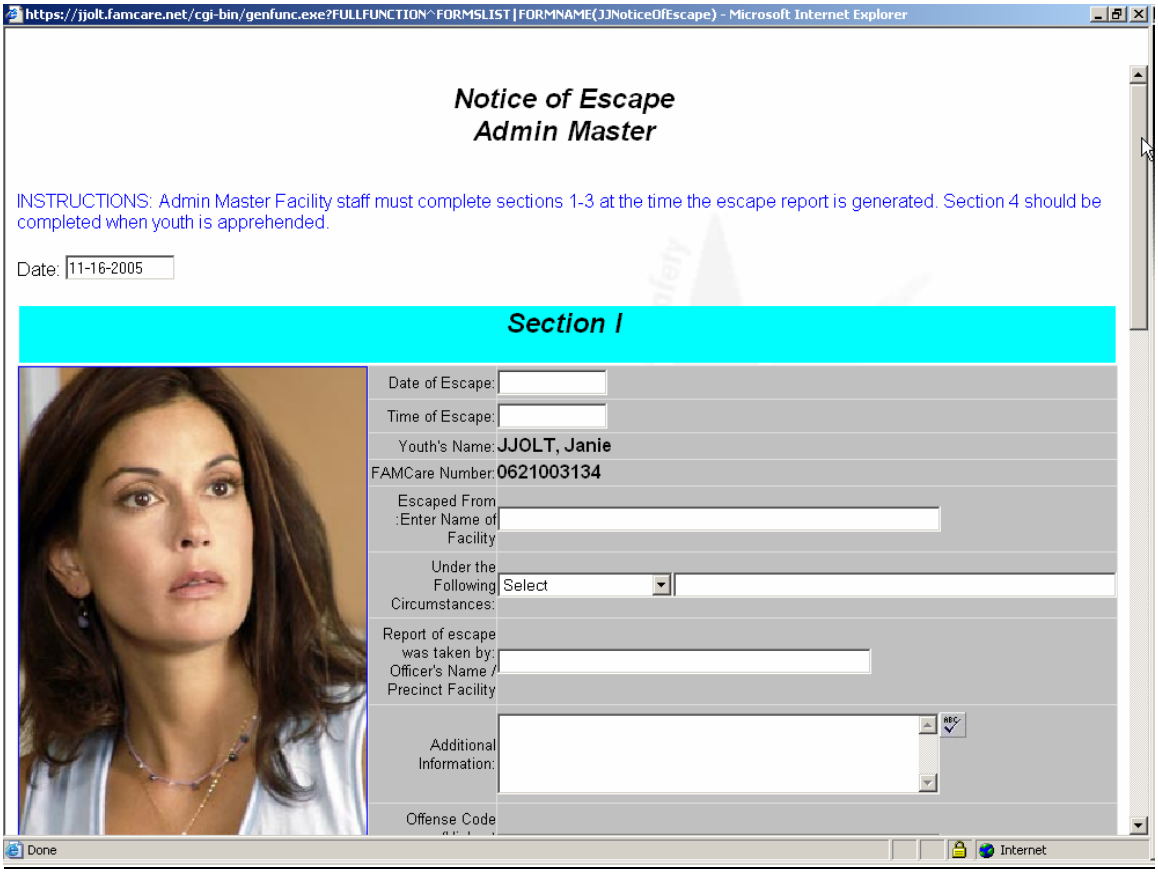
At the bottom of the drop-down menu select "Logoff FAMCare.

To complete a Notice of Escape, go to the DHS forms menu. Select 5A to access the notice.

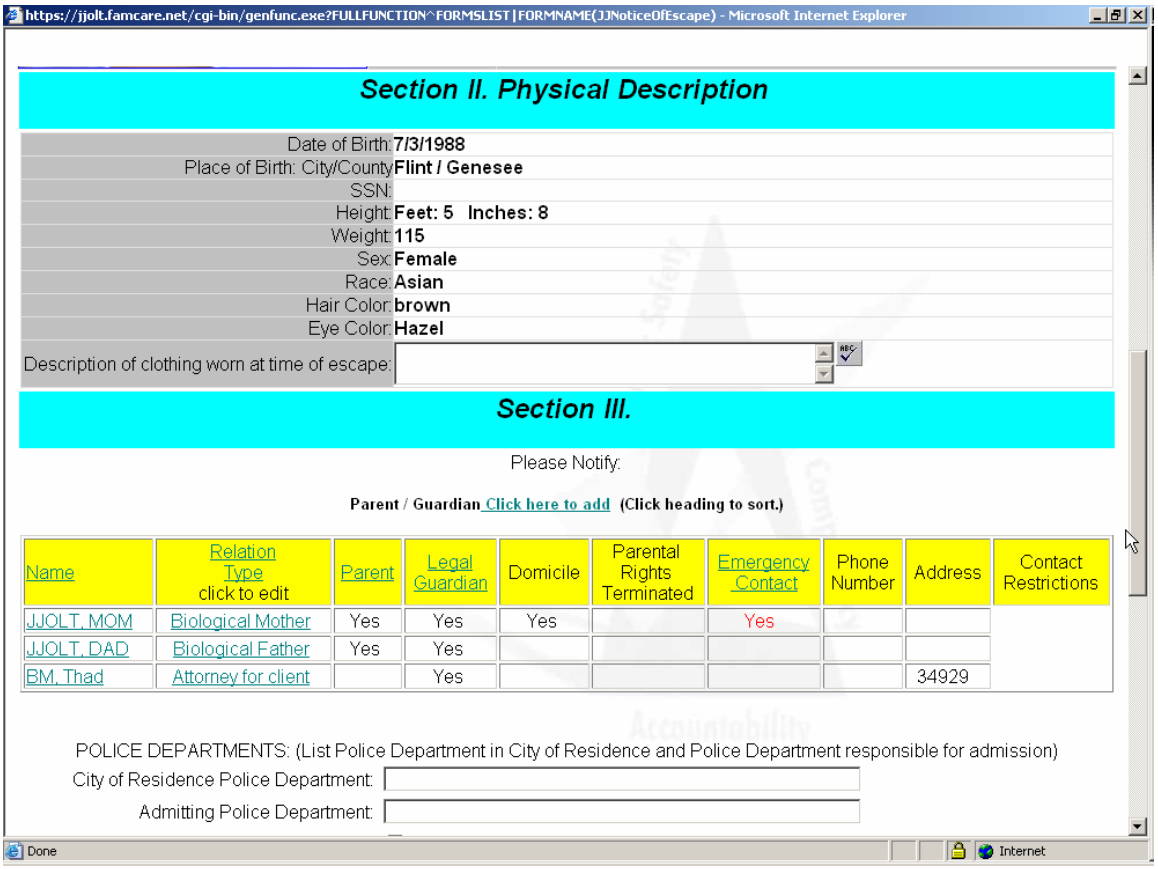


After selecting 5A you will see the Escape summation page, which will allow you to create a new notice or copy an existing one. If you are creating the first one for your facility, it should be create new. For each additional notice, you can copy existing. Please see example on next page.





You can now begin to fill out each section of the notice. Information regarding description of client, along with parent / guardian history will automatically pre-fill from the client intake summary. This is why the intake summary should always contain current information regarding the client and family. You must always include a description of clothing worn at the time of escape



There is a section where you must list the city of residence police department, officer taking the complaint, etc. Once you have entered the necessary information, click the save button at the bottom of the form. There will be an automatic E-Mail notification sent to the DHS director's office, JJS worker, your facility Director, etc. You must also follow up with a phone call to the JJS worker, and others you deem necessary.

Once the client has been apprehended, you must complete the section shown below and then save. Auto E-Mail notifications will Once again will go to those listed on the previous page, notifying them of the date and time of apprehension, where the client is currently lodged, etc.